Report of the Health Planning Task Force

Ontario

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Health Planning
Task Force

1974

Letter of Transmittal

January 28, 1974

The Honourable Robert Welch, Q.C., L.L.D.
Provincial Secretary for Social Development

The Honourable Richard T. Potter, M.D., M.C.F.P.
Minister of Health

Sirs:

We respectfully submit herewith our report on health planning, in accordance with the terms of reference approved by Cabinet on January 10, 1973.

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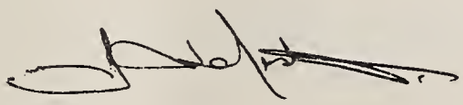

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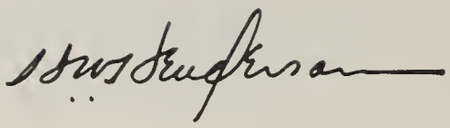

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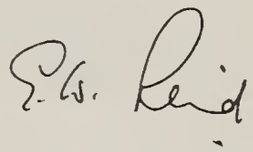

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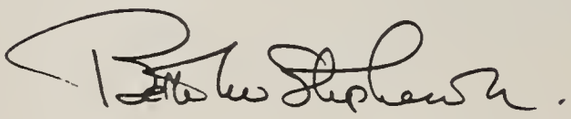

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Terms of Reference

The terms of reference of the Health Planning Task Force are as follows:

> The committee is asked to develop proposals for a comprehensive plan to meet the health needs of the people of Ontario. The plan should be realizable with the forecast available fiscal resources, and should provide for implementation by voluntary means. The plan should also provide for the eventual coordination of health and social services.
>
> In addressing this work the committee is requested to identify the main issues, list feasible alternative courses of action, estimate the consequences of these, and make recommendations for the consideration of the Minister of Health and the Cabinet Committee on Social Development. To the maximum extent possible, the committee is requested to employ interim reports so that the most pressing problems can be addressed without delay.

Acknowledgements

Technical support in the preparation of this report was provided through the auspices of the Research and Analysis Division of the Ontario Ministry of Health.

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Recommendations

Our discussions concerning the development of a comprehensive health plan for the people of Ontario have led us to the concepts of primary and secondary care. Primary care constitutes the major health care sector. It is the first point of contact for the individual with the health system and, as we see it, should provide services on a continuous basis. Secondary care is a resource to primary care. In this sector, health services are provided to those individuals who require more specialized health care than that which is available in the primary sector. Normally, the individual will be referred to secondary care from primary care. This is not, however, to suggest that the primary sector transfers all responsibility for the patient. The links between primary and secondary care must be sufficient and strong enough to ensure continuity of care, regardless of where the services are provided.

The focus of this report, then, is on the development of primary health care and on the effective coordination and integration of services within and between the two sectors. Special organizational arrangements will have to be made to permit and encourage the achievement of these objectives. The key elements of the arrangements that we propose are a District Health Council for planning and an Area Health Services Management Board for operations at the local level; a Regional Director and a fully staffed regional office to act for the Ministry of Health at the community level; and a number of changes in the central office structure for the Ministry designed to strengthen its role in the delivery of health services in the community. We also propose that special financial arrangements be made to promote the development of the primary care sector, and that educational programmes be developed in relation to the needs of the health care system. In addition, priorities should be set for health research in the province, so that such efforts may be directed to the areas where new developments are most urgently needed. Coordination of research efforts also is important to ensure efficient resource use.

To make possible the development of a comprehensive health care system and to achieve the objectives outlined above, we make the following specific recommendations:

1. The primary care sector should be developed to fulfil the following responsibilities:

    a. Provision of primary contact for the public with the health system, twenty-four hours a day and seven days a week

b. Complete and continuous responsibility for the health care of the individual and the family, including promotion of preventive measures and of the need for health maintenance on the part of the individual

c. Determination of the kind of health services that are required by the individual at a given time

d. Provision of health care based on a continuing health professional/patient relationship that is characterized by mutual confidence and understanding

e. Establishment of arrangements for the sharing of tasks and the delegation of responsibility among all health personnel in the group in order to achieve optimal efficiency in the provision of health services of high quality

f. Establishment and operation of an evaluation procedure based on an audit of health services and a review of the performance of health personnel by their peers

g. Provision of recommendations to the proposed District Health Services Advisory Committee regarding requirements for primary care health services and distribution of these services

h. Provision of recommendations to the proposed District Health Services Advisory Committee concerning manpower requirements for the primary care sector

2. The secondary care sector should meet the following requirements:

a. Provision of an effective consulting and advisory service for the primary care sector, twenty-four hours a day and seven days a week

b. Development of programmes within a district according to the need for services for special health problems

c. Provision of recommendations to the proposed District Health Council concerning the specialized and very specialized services required and the location of facilities

d. Establishment and operation of an evaluation procedure based on an audit of health services and a review of the performance of health personnel by their peers

e. Provision of recommendations to the proposed District Health Services Advisory Committee concerning manpower requirements for the secondary sector

3. Services should be organized by district and by area. Districts have geographical boundaries, though these boundaries are not determined by geography alone. Areas comprise sub-units within districts and represent spheres of influence.

4. District Health Councils should be established throughout the province as

rapidly as possible. These councils should be established by statute and given the responsibility for recommending to the Ministry plans for the delivery of health care in each district. These plans would include the programmes to be carried on, required manpower and the use and location of facilities. The District Health Councils also should be responsible for ensuring that mechanisms exist for maintaining the quality of care in the district.

5. Area Health Services Management Boards should be created by statute to facilitate the integration of the delivery of care in the primary and secondary care sectors in areas within a district. The Boards would be responsible for

    a. operating one or more institutions
    b. providing administrative support to secondary care programmes and primary health care groups
    c. developing and monitoring mechanisms to ensure the quality of care
    d. implementing planning decisions

6. The District Health Councils must establish mechanisms that will ensure the evolution of primary health care groups. These would consist of primary care physicians, nurses and other health care professionals working together to provide a wide range of health services and to make the maximum use of their individual abilities.

7. Regional Directors for health services should be appointed to act for the Minister in carrying out his responsibilities in the health care system throughout the province. Each Director should have a full complement of support staff and be located in the geographic region that contains the districts for which he/she is responsible. The Director's role is to assist District Health Councils, Area Health Services Management Boards and institutions in carrying out their statutory responsibilities. He/she should have sufficient authority delegated to him/her within the overall guidelines of the Ministry to permit rapid decision-making, and should have access to support staff in the Ministry's central office.

8. The central staff of the Ministry should concentrate its efforts on developing overall objectives, priorities, guidelines and standards for the province, making major decisions and providing support to Regional Directors. The organization structure of the Ministry should be revised to include a Research and Development Division and an Information Services Division, both directly responsible to the Deputy Minister of Health. The role of the Communications Branch should be expanded to include an active information programme directed to the education of the public in measures for the promotion and maintenance of health and the prevention of disease.

9. Special funding arrangements should be made to promote the development of primary health care.

10. Manpower planning and control should be introduced by having each District Health Council decide, within provincial guidelines, the number of positions to be established for various categories of health personnel, according to district requirements. A physician holding one of these positions would be eligible for registration under the Ontario Health Insurance Plan. Individual physicians would be free to seek out the positions that they wished to fill in all regions of Ontario.

11. Clinical education of health personnel should be balanced to include both the primary and the secondary care sectors, and the clinical programmes should be conducted throughout the health service programmes in the districts.

12. A health services research programme for Ontario should be developed, providing for the coordination of research activities of the Ministry of Health, the universities' health sciences centres and the proposed District Health Councils, and linking such activities to the health needs of the community.

Implementation

The difficulties of implementing our proposals should not be underestimated. They have been developed on the fundamental assumption that the health care system should evolve from existing arrangements; thus, they will take some time to implement. In addition, the present network of health services and the mix of public, private and voluntary effort are large and varied, and change may not come naturally, easily or quickly. Unless special steps are taken to plan and monitor progress, the time lag could be unacceptable.

The officials of the Ministry of Health have the responsibility for carrying on their present duties and are heavily involved in developing guidelines for the future. While it is essential that they play a major part in development of the proposals set out in this report, they will require assistance. It is therefore recommended that the government set up a special Implementation Group responsible to the Minister. This group should consist of individuals drawn from departments of government and from outside government. It should be given sufficient authority to ensure that the recommendations of this report are carried out.

The first task of such a group would be to analyze the steps that will have to be taken in order to carry out the proposals and to recommend to the Minister detailed plans and priorities. The second step would be to assign responsibility, with the assistance of Ministry officials, for the various tasks to be performed. The third step would be to draw up specifications for each task and a timetable to be used by those charged with the responsibility for carrying out the task.

It would then be necessary to monitor progress, to make sure that delays in the completion of some of the tasks would not affect the overall implementation, and to recommend to the Minister steps that could be taken to keep the plans on schedule.

It is believed that such a group could greatly assist the Ministry personnel in carrying out their responsibilities for introducing the proposals.

Much of the change at the local level will be effected through the District Health Councils, through local health professionals and through Task Forces that may be established for this purpose. The Regional Directors for district health services will aid in this activity; they and the District Health Councils must be given sufficient resources to enable them to undertake their responsibilities.

We are aware of the major problems involved in implementing proposals as broad in

scope as those included in this report. Competent people and considerable financial resources must be made available. Implementation should be undertaken without delay, however, to develop a health services system that will meet the present health needs of the people of Ontario and provide a basis on which future needs can be met.

1 Introduction

This Task Force has been charged with the responsibility of developing proposals for a comprehensive plan to meet the health needs of the people of Ontario. The problem of devising such a plan is compounded by the extraordinary breadth and scope of the concept of health.

Most persons regard health as the mere absence of pain and disease. Consequently, they see health care as the major force leading to improvements in health. There is no doubt that health care services have had remarkable success in reducing morbidity and mortality from infectious disease and in developing new surgical procedures for dealing with some acute and chronic manifestations of disease and injuries. The reduction in the rate of infant mortality in Canada from 61 deaths per 1,000 live births in 1941 to 17 deaths per 1,000 live births in 1971 is in part another example of the benefits of improved health services. It is important, however, to realize that health care services have not been and will not be the main factors in raising the level of health of the nation or the province.

The findings of McKeown are of particular importance here:

> In order of importance the major contributions to improvement in health in England and Wales were from limitation of family size, increase in food supplies and a healthier physical environment, and specific preventive and therapeutic measures....Past improvement has been mainly due to modification of behaviour and changes in the environment and it is to these same influences that we must look particularly for further advance.[1]

It is our contention that to produce significant changes in morbidity and mortality, efforts will have to be directed to the underlying causes. The important point is that these causes arise in areas not normally associated with health care.[2] An example will illustrate the point. In Canada, two principal causes of morbidity and mortality in persons between the ages of twenty and seventy are accidents (primarily motor vehicle accidents) and diseases of the cardio-vascular system. It is recognized that high-fat diets, smoking and, to a degree, lack of exercise are associated with increased risk of cardio-vascular disease. Thus, unless there are changes in society, so that self-imposed risks are reduced and people adopt effective preventive health measures, present rates of morbidity and mortality will not change significantly.

1 G. McLachlan and T. McKeown, eds., **Medical History of Medical Care. A Symposium of Perspectives** (Toronto: Oxford University Press, 1971), pp. 36 and 49.

2 H.L. Laframboise, "Health policy: breaking the problem down into more manageable segments", **Canadian Medical Association Journal,** Vol. 108, No. 3, pp. 388-93.

To some extent, it is and must be the individual's responsibility to maintain his or her health. How this attitude can be fostered widely in the public, largely indifferent to health until disease strikes and constantly encouraged by advertising to cultivate habits injurious to health, is a fundamental issue to which society must address itself. It is clear, however, that in the long term, changes in current attitudes and habits will contribute far more to the improvement of health than increases in the quantity of health services provided or increased application of expensive technology to the end stages of human disease. For this reason, we are convinced that the health care sector must devote a substantial effort towards health promotion, disease prevention and health maintenance on the part of the individual.

It is important to note too that government should focus its attention on those areas of the socio-economic environment that affect the health of the individual. Factors such as housing, recreation facilities, education and employment opportunities directly influence the individual's well-being and therefore his health, in the broadest sense of the word. Because of this intermingling of factors, the health care sector should be developed in close relationship to educational, social and community services. Programmes in all these areas should be directed towards the common objective of ensuring the individual's well-being.

It is apparent from the foregoing discussion that a truly comprehensive health care system must be capable of dealing with the prevention of disease and with the promotion and maintenance of health. It must, then, incorporate a health education programme, as well as provide adequate and accessible services. The majority of people name their family physician as the main source of health information and identify him/her as the source they find most helpful and trustworthy.[3] At present in Ontario, the provision of health care focuses on treatment services; the linkages between health and education of the public and between health and social services have not been well developed. A comprehensive system must make possible the development of such linkages, and it must facilitate the achievement of overall health objectives in all areas of our society. At the same time, comprehensive health care requires the provision of services on a universal and accessible basis. In this respect, it is useful to review the role of the Government of Ontario in the provision of health care to residents of the province.

During the past two decades, the government has taken important steps in the health field by establishing a series of programmes designed to alleviate the financial burden of health care for the private individual. In the 1950s, a cost-sharing plan was introduced to help cover the cost of hospital operations; in 1959, the Ontario Hospital Services Insurance Plan came into effect. Commencing in 1965, medical services insurance became available under a government plan, and in 1969, this plan provided for universal coverage. Hospital and medical insurance were combined in 1972 under the present Ontario Health Insurance Plan (OHIP).

3 Harris Survey of U.S. Adults, 1971 Blue Cross Association.

Under OHIP, Ontario residents are covered for combined hospital and medical care insurance through premium payment to the Plan.[4] Premium-free insurance is available to those with no taxable income and to all residents aged 65 years and over; 50 per cent premium assistance is available to other low-income persons. The scheme covers almost all the residents of Ontario, and its coverage extends outside the province and outside Canada.

The cumulative effect of the Province's initiatives has been the underwriting of a very substantial portion of health care costs for the residents of Ontario. In 1973-1974, the government's expenditures on health services alone exceeded $2 billion.

The provision of universal health insurance has not automatically improved the level of health for the population of Ontario. While it is true that under OHIP many people have been able to obtain medical services that they could not afford in the past, in certain areas of the province residents still do not have access to the services they need; and more significantly, where the need for services is greatest, few measures have been undertaken to influence the social and environmental causes of ill health and none in coordination with the provision of remedial services. In short, no plan has been developed for the delivery of health services in relation to the overall needs of the population.

Some problems inherent in the current arrangements are the concentration of specialty services within hospitals; the random dispersal of general physicians throughout the province, without regard for community need; the lack of coordination among specialty services, family practitioners, public health services and other personal health services; and inaccessibility to services in certain areas of the province. The Pickering Report has described well the problem of fragmentation of services:

> A commonly voiced complaint at the Hearings and registered in Public Opinion Survey, is that the practice of medicine has increasingly become fragmented. The patient goes to one doctor, is sent probably on different days for X-rays, laboratory tests and perhaps to a specialist or two. There are frequently long delays between these various steps and frequently there is a long delay before the patient is informed of the overall results if, indeed she is informed at all. Management of the patient's problem tends to be unco-ordinated. The patient often feels she is regarded as a series of symptoms and is not treated as a whole person, but as "another OHIP number". The impersonal attitude of many doctors towards their patient may be due to an excessive workload, but the fact remains that the public is highly critical of the virtual disappearance of the person-to-person element in the practice of medicine.
>
> The fragmentation process tends to scatter the patient's records at a number of points instead of being centrally located in one office. This presents difficulties when the patient requires treatment, particularly under emergency

4 The premium accounts for about 25 per cent of the total government funds used to meet health costs.

conditions. It presents a problem as well when the patient moves to another city, as is happening more and more frequently in our mobile society.[5]

Given the size of the government's investment, it is understandable that it should concern itself with the judicious and efficient use of its funds. Moreover, there is growing concern over the rate of increase in health costs. This is a problem in many Western jurisdictions, but it is particularly severe in Canada. Here health care expenditures account for over 7.3 per cent of the Gross National Product; and according to the projections of the Economic Council of Canada, the rate of growth of health care expenditures by all levels of government in Canada between 1967 and 1975 will increase "faster than [that of] any other major category of government spending".[6] In Ontario, despite government measures to constrain cost increases in the health care sector, government expenditures between 1970-1971 and 1973-1974 rose from $1.6 billion to $2.2 billion.[7]

It was only to be expected that health costs would rise in Ontario, in view of the fact that under OHIP more people were using health services than had previously been the case. The cause for concern, however, has been the proportion of costs incurred in providing health services as related to the benefits resulting from their provision. It appears that the two are not in balance.

Unless the allocation of the resources available for health care is carefully planned and controlled, these resources will soon become inadequate to meet many of the health needs of Ontario's citizens. This means that priorities will have to be set for the use of all health care resources – human and physical, as well as financial.

Viewed in combination, these factors point to the need to develop an integrated, coordinated system of health services that will provide high quality health care on an accessible basis throughout the province. Duplication of services will have to be eliminated, and coordination of programmes must be achieved to avoid further fragmentation and wasteful resource use.

If the health services system that is developed is to be truly effective in meeting health care needs, both health professionals and Ontario residents (the users of health services) will have to participate in the selection of priorities and the integration of services. We believe that community input will be increasingly important in determining which new health services should be introduced and which existing services should be modified. A better-informed public will have higher expectations of the quality of life, will be less tolerant of frustration of these expectations and will insist upon more direct participation in decision-making on

5 Edward A. Pickering, **Report of the Special Study Regarding the Medical Profession in Ontario**, April 1973, pp. 81-82.

6 Economic Council of Canada, **Patterns of Growth** (Ottawa: Queen's Printer, September 1970), p. 40.

7 This represents approximately 28 per cent of total provincial government expenditures.

policies and priorities in publicly supported services that affect them personally. They will have to be sufficiently well informed to understand and accept the need for more rational use of resources, even where this involves some inconvenience or a blow to civic or institutional pride.

For efficiency and effectiveness, some centralization at the local level will be necessary, although care must be taken not to jeopardize the personal relationship that exists between health professionals and those they serve. Also, the central guidelines that form the basis of the health services system will have to incorporate sufficient flexibility to permit adaptation to local needs.

Another necessary aspect of the health services system is a central system for accountability. Such a system will be required as long as the Province is involved in the funding of health services; and it is particularly important when the investment is a substantial one and when a primary objective is the optimal use of such funds.

Any changes that are made in the organization of delivery of health services will require related adjustments in the training and education of health professionals. To match the integration and coordination of the system, and to allow the development of appropriate attitudes, educational programmes will have to give a balanced emphasis to all aspects of a comprehensive health services system. Some of the programmes should be offered in the type of setting where the students eventually may practise. Health professionals also should be equipped with a working knowledge of the broad health sector in which they serve.

We are fortunate in Ontario in that the present institutions, personnel and arrangements within the health care sector represent, for the most part, a sound base on which to build a comprehensive system. It is neither necessary nor desirable to sweep away the solid foundation of programmes, services and traditions on which health services now rest. Our proposed plan therefore projects a system that can evolve from existing arrangements. We are aware that many changes are currently taking place in the health care sector that conform to the general direction of our recommendations. We are confident that, with the cooperation of all persons involved in health care, an efficient system of high quality health services can evolve that will meet existing needs and also will be capable of meeting the needs of the future.

2 The Foundation of a Health Care Plan for Ontario

The mandate of the Health Planning Task Force, as stated in the terms of reference, is "to develop proposals for a comprehensive plan to meet the health needs of the people of Ontario". In devising this plan, we have taken into account the existing arrangements for providing health services, the current and projected future needs of the public, the resources that are available, and the respective roles of government and health professionals in the health care field.

The health care plan that we have developed is based on an overall objective and a number of guiding principles. These are briefly described in the pages that follow.

Objective

The basic objective of Ontario's health services plan is to provide and maintain for residents of the province a state of physical, mental and social well-being, including the prevention or treatment of disease or infirmity, to the extent possible given the resources that are available.

In seeking to attain this objective, the Ministry of Health must perform a dual role: it has ultimate responsibility for the overall planning and financing of a comprehensive health care system; and in a broader context, it must facilitate and encourage the development of programmes in related areas – such as education, environment, recreation, housing and social services – that also will contribute significantly to the individual's well-being.

Guiding Principles

The Task Force has adopted the following guiding principles for the development and operation of a comprehensive health care plan.

Availability

Health services must be available to all residents of the province, twenty-four hours a day, seven days a week, within the limitations imposed by types of health problems, resources and geographic factors. This does not mean that all services will be available in each community, but rather that they will be distributed throughout the province in proportion to the needs of the population to be served.

Accessibility

Health services must be not only available, but also accessible. People must be made aware of the range of services that is available to them; and their voluntary use of such services and ease of entry into the health services system must be assured. Where necessary, transportation services should be developed to facilitate access.

Continuity

The health services system must allow for continuous, coordinated care, encompassing the complete spectrum of health services available in Ontario.

Focus of System

There must be a shift away from the traditional focus of health services in a hospital setting to community settings accessible to the public.

Range of Services

The health care system must encompass services for the physically ill and the mentally ill, and for individuals who are ambulatory and those who are not. Services are not limited to institutional care but include home care as well. They include the promotion of health and the prevention of disease, as well as the treatment of disease and rehabilitation. Part of the responsibility related to promotion and prevention lies in the health sector and part lies in other areas, such as education, recreation, housing and social services.

Efficiency

The optimal use of resources will be attained by the efficient and effective delivery of services. Provision of unnecessary services should be eliminated. Services should be grouped where possible, and tasks should be assigned to personnel in accordance with their training and ability.

Integration and Coordination

The provision of health services should be structurally and functionally integrated and coordinated throughout Ontario, to ensure adequacy of services, to avoid duplication and fragmentation in delivery of services, and to permit maximum use of the health care resources available to the Province. Coordination also should be achieved between health and related services, such as community and social services and education. Separated, isolated functioning should be discouraged.

Innovation

There should be a built-in capacity to foster innovation in methods of delivery of health care and in testing new programmes. Such innovation must be accompanied by evaluation.

Evaluation

There must be evaluation of the effectiveness of both new and established programmes. This relates to the principle of optimal resource utilization in that it indicates which programmes should be continued, which abandoned and which modified.

Decentralization

In the health field, the actual delivery of services is decentralized. The administrative arrangements for health services, including those of the Ministry of Health, should be decentralized so as to be compatible with the delivery of services.

Pluralism

Within guidelines established by the Ministry of Health, the health services system should be sufficiently flexible that the provision of services in a given community can be readily adapted to the community's particular needs, taking into account specific social, economic, geographic, cultural and other local factors.

Evolution

Changes in the health services system should evolve from the blending of the best features of the existing arrangements with programmes that have been newly developed and evaluated.

3 A Comprehensive Health Services System

The implementation of the health care plan will be effected through the development of a health services system and appropriate organizational arrangements. In accordance with the guiding principles outlined in Chapter 2, the health services system must provide continuous, high quality health care that is available and accessible to residents of Ontario. This chapter describes our proposal for such a system.

Approach to the Delivery of Services

A key element in our proposal is our endorsement of the group approach to delivery of health care services. This is not a new concept. Indeed, the trend towards the grouping of health professionals to provide services has been recognized in several recent studies of health care.[1] The Committee on the Healing Arts, for example, has noted that

> there has been a very considerable increase in group practice in Ontario over the last few years. There appears also to be a growth in less formal arrangements....We believe that the future of organization of practice lies in the direction of combined practice.... Indeed,... many people, both in medicine and outside, believe that the best setting for the practice of the well-trained general physician is in some kind of group.[2]

More recently, the Pickering Report has referred to the almost unanimous desire expressed by the general public for some form of group practice, and the wide agreement among Ontario's physicians that increasingly the members of their profession are turning to group practice.[3]

We support the group approach because it is the only alternative for the delivery of services that satisfies the three essential requirements of the health care system. Through the grouping of professionals, it is possible to make health care services available to residents of the province on a twenty-four-hour basis; the public has

1 **The Report of the Commission of Inquiry on Health and Social Welfare** (Quebec: Queen's Printer, 1967), Vol. IV, Tome II, p. 30. **The Report of the Community Health Centre Project** (Ottawa: Information Canada, 1973), p. 2. **The Report of the Ontario Council of Health on Health Manpower** (Toronto, 1970), pp. 12-13. **The Task Force Report on the Cost of Health Services in Canada** (Ottawa: Queen's Printer 1970), Vol. 3, p. 64.

2 **Report of the Committee on the Healing Arts** (Toronto: Queen's Printer,1970),Vol.3,p.207.

3 Edward A. Pickering, **Report of the Special Study Regarding the Medical Profession in Ontario,** April 1973, pp. 27,33.

ready access to a range of services to meet a wide variety of health care needs; and continuity of care is facilitated by the liaison of professionals dealing with a single individual. In addition, we feel that grouping constitutes the best means of making maximum use of the skills of health personnel. It is a fact that patients have to be referred from one professional to another in order to receive appropriate care. For example, a patient may seek advice from a physician regarding a problem that is social or psychological, rather than medical. The physician may spend considerable time in identifying the patient's needs and subsequently in persuading the patient to accept referral to the appropriate facility. Moreover, the patient may be reluctant or unable to follow up the referral if the care facility is distant from his home or place of work. Through a group arrangement, the diagnosing physician can direct the patient immediately to the professional who is best qualified to handle his problem and in many cases this person will be located on or near the premises.

The success of the group approach depends heavily, of course, on the degree of cooperation that can be achieved among health professionals working in this setting. Dana and Sheps have described the essence of this approach:

> Interprofessional behaviour.. does not require members of related professions to think alike, but rather to act together.... It asks that the professional person put problem ahead of profession and/or institutional auspices ... [and] necessitates that he respect both himself and others as having knowledge, understanding, skills, and, most importantly, equal right to participate in the problem-solving process.[4]

In this respect, we feel that the attitude of the professional associations will encourage the evolution of a smoothly functioning team system. The Ontario Medical Association, the Canadian Medical Association and other groups of health professionals have in the past taken an active part in stimulating the development of new arrangements for the provision of health services. For example, at the end of World War II, the Canadian Medical Association officially endorsed and supported proposals for a comprehensive national plan for health care, including publicly administered health insurance. The CMA also was influential in the establishment of the Royal Commission on Health Services (1964-1965) and, with the provincial medical associations, has made valuable contributions to subsequent studies of health problems at the national and provincial levels. It is significant, too, that the Pickering study referred to earlier was commissioned and the report subsequently endorsed by the Ontario Medical Association.

In view of the positive and responsible attitude demonstrated by these professional associations, we are optimistic that the necessary cooperation will emerge among the health professions to make possible the group approach to delivery that is essential to a comprehensive health care system.

4 B. Dana and C. Sheps, "Trends and Issues in Interprofessional Education: Pride, Prejudice, and Progress", **Journal of Education for Social Work**, 4:37, Fall 1968, pp. 37-38.

Basic Elements of the System

The health services system is an aggregate of interrelated health services arranged so as to function as a complex whole. Within the system, there are two distinct sectors: primary care and secondary care. Primary care services are provided by groups of medical and allied health personnel; each group, in the provision of such services, contributes to an overall programme[5] of primary care in the community. In the secondary care sector, the services of specialists are grouped around programmes or areas of specialty.

The concepts of primary and secondary care are basic to our proposals for health care in Ontario. It is through the development of integrated and coordinated primary and secondary care services that the quality and efficiency of future health services will be maintained and improved. We shall now describe in some detail how these two sectors are expected to function in the new health services system.

Primary Care

Primary care includes not only those services that are provided at first contact between the patient and the health professional, but also responsibility for promotion and maintenance of health and for complete and continuous care for the individual, including referral when required. As our previous comments indicate, we are convinced that primary care can be provided most effectively through group arrangements.

The primary care group can be described organizationally as a number of health professionals grouped together to meet primary health needs in a given geographic area on a continuous (twenty-four-hour) basis. The organizational grouping does not necessarily imply a common physical location, but it should make possible a more effective utilization of the skills of health professionals within the group and provide for a range of health services that are available, accessible and continuous.

The primary care group will function as a team. Under this arrangement, maximum use should be made of the skills and experience of each member.

The functions of health personnel in the primary care group include prevention, health promotion, health maintenance, consultation, education, diagnosis, treatment and rehabilitation. The particular function of the certified family physician has been described by the College of Family Physicians:

> A Certified Family Physician shall be skilled in establishing and maintaining relationships with patients and associates which facilitate maximally, the provision of health care. He shall be skilled in sensing and formulating all health problems and investigating and managing common health problems. He shall be able to arrange through consultation and delegation, the provision to

5 The term **programme** in this context refers to a broad grouping of interrelated health services directed towards a specific health objective—thus, for example,, there are maternal and child health programmes, cardio-respiratory programmes and rehabilitation programmes. A programme is subject to the availability of manpower, facilities and financial resources; it is subject also to evaluation.

patients of those elements of health care which are better provided by other health professionals. He shall be technically competent at those procedures commonly required in primary care. He shall provide or arrange for a constantly available health service to persons regardless of their age or problem. He shall select for patients, those preventive and screening procedures, as well as methods of investigation and management, which are established as worthwhile. He shall continuously review and up-date his competency and be capable of assessing pertinent research.[6]

We believe that this function can be performed most satisfactorily through the primary care group.

Primary health services developed through primary care groups should be able to meet more than 80 per cent of the demand for health services in a comprehensive health care system; the remaining needs would be met by secondary health care services.

The primary care sector has eight specific responsibilities:

1. Provision of primary contact for the public with the health system, twenty-four hours a day and seven days a week
2. Complete and continuous responsibility for the health care of the individual and the family, including the promotion of preventive measures and of the need for health maintenance on the part of the individual
3. Determination of the kind of health services that are required by the individual at a given time
4. Provision of health care based on a continuing health professional/patient relationship that is characterized by mutual confidence and understanding
5. Establishment of arrangements for the sharing of tasks and the delegation of responsibility among all health personnel in the group in order to achieve optimal efficiency in the provision of health services of high quality
6. Establishment and operation of an evaluation procedure based on an audit of health services and a review of the performance of health personnel by their peers
7. Provision of recommendations to the proposed District Health Services Advisory Committee[7] regarding requirements for primary care health services and distribution of these services
8. Provision of recommendations to the proposed District Health Services Advisory Committee concerning manpower requirements for the primary care sector

The primary care sector is the point of first contact for the individual for virtually all major and minor ailments. Most disorders managed in primary care are such that

6 The College of Family Physicians, **Educational Objectives for Certification in Family Medicine,** Part 1,1974.

7 See Chapter 4.

they are unlikely to threaten the patient's life or lead to serious complications. About a third of the cases seen are chronic, and treatment of them requires some major adjustments in the patient's way of life.

The precise mixture of health personnel in a primary care group will depend upon the size and requirements of the area in which it is located and the availability of personnel. The number of individuals with chronic health problems emphasizes the need for well-developed rehabilitation services. These services are an essential part of primary care and include physiotherapy, occupational therapy, social work and psychiatry.

The greatest users of a physician's time are children under two years of age, women of child-bearing age and elderly people. Thus, some members of the primary care group should have a special interest in developmental and social paediatrics, maternal health and geriatrics. Mental health problems are so common throughout the population that personnel in primary care also should be skilled in handling these disorders.

On the basis of the number of physicians and nurses required to provide continuous service and the need for some to have areas of special interest, a team of five or six physicians and five or six nurses is probably the minimum for a group. In a group of this size, a primary care physician or nurse could have a special interest in one field – for example, general medicine, obstetrics, child care with particular emphasis on prevention of disease, geriatrics or mental health. This individual would not, however, be a specialist in the sense of a person trained to provide specialized care. The nurse in primary care would fulfil those functions now carried out by public health nurses, including visiting nurses and nurse practitioners.[8] Thus, under the broad concept of primary care, the term nurse encompasses all nursing categories. In addition, a full-time social worker could be associated with the group. Such a group could serve a population of 10,000 to 15,000.

A larger group could have a more diversified composition, as is the case with the large group practices that already exist in some parts of the province. Such a grouping might well have a number of specialists associated with it, on a continuous or visiting basis. Their main concern would be to deal with the special problems that emerged through the primary care group. Regardless of their physical location, the services provided by these specialists would necessarily be coordinated through the mechanism of the secondary care sector (described later in this chapter).

8 The Committee on Nurse Practitioners has offered the following definition: "Nurse Practitioner or Family Practice Nurse: a nurse in an expanded role oriented to the provision of primary health care as a member of a team of health professionals, relating to families on a long-term basis and who, through a combination of special education and experience beyond a baccalaureate degree or diploma, is qualified to fulfil the expectations of this role." **Report of the Committee on Nurse Practitioners** (Ottawa: Department of National Health and Welfare, 1972), p.1.

Physicians specializing in one area of general medicine – such as general paediatricians and general obstetricians – could serve a number of primary groups in a given community; the number and mix of these professionals in the community would vary according to the local need for their services.

In larger groups, there also could be justification for the inclusion of other health personnel, such as pharmacists. Indeed, we must emphasize here that if Ontario's health care system is to be truly comprehensive, it must encompass **all** health services – medical, dental, optical and various other types of service. Under the present funding arrangements, it is difficult to include dental and other non-medical personnel in the primary group as we conceive it.[9] We feel, nevertheless, that this problem must be faced and that means should be found for allowing these professionals to participate in primary care groups.

It may not always be necessary for a primary care group to include all health personnel on a full-time basis. For example, in rehabilitation the services of an occupational therapist or physiotherapist may be required frequently but not full time. More specialized services, such as those in alcohol or drug addiction, also may be required on an intermittent basis. The personnel who provide services of this nature could be organized as a resource to primary care groups, providing services to each particular group as the need arose. If a primary group developed a need for full-time services, one or more individuals could become full-time members of the group. Such individuals would, however, take part in the overall programme in their district, to ensure the coordination of their services with those provided to other groups serving the community.

The health personnel providing personal health services through local boards of health and other agencies should become members of primary care groups, or arrangements should be made to second them to the primary care groups. In addition, because a significant number of individuals seen in the primary health care sector have social as well as medical problems, close working arrangements should be developed between health and social services at the local level.

Arrangements should be made between the primary care group and the various health care institutions in the community – hospitals, nursing homes, rehabilitation centres, chronic care units, homes for the aged – to permit the primary care physician to provide or arrange for his patient's treatment in the appropriate setting. In addition, there must be access by primary care physicians to support facilities, such as laboratories, available within the area.

The actual organization of each primary care group throughout the province will

9 The main problem is to develop a viable system of remuneration for the members of the primary group. We address this question in Chapter 6 of this report.

vary depending on the population density of the area to be served and the patterns of health personnel grouping that will evolve. The following are some examples of possible arrangements:

1. In a fairly isolated area, there might be a nursing station with two or more nurses who will act under the supervision of a physician in a more central community. This physician may be a member of a group based in a still larger community some distance away. Thus, a group could consist of six physicians physically located in two or three different communities and twelve nurses, some of whom will be located in smaller communities than those in which the physicians are based.
2. A community health centre might be established in which all physicians, nurses and allied health personnel are located. The Report of the Community Health Centre Project Committee has emphasized the importance of such an organization for the delivery of health services.[10] We believe that the development of community health centres is not an immediate solution to the problem of providing primary care services, and in some parts of the province it may not be feasible.
3. In some urban settings, physicians forming the primary care group may operate out of separate locations, working with a pool of nurses and other allied health personnel.

Figure 3-1 illustrates each of these alternatives in diagrammatic form.

Secondary Care

The secondary care sector is a resource to the primary care sector. Patients will normally enter secondary care by referral from primary care. The health problems of the patients seen in secondary care will be those that require specialized skills and facilities not available in the primary care sector.

The types of problems seen in secondary care can be divided into two categories, according to the degree of special skills and resources required for their treatment. The first category includes serious cardio-vascular disorders, major accidents, burns, major fractures, cancers, major behavioural disorders and special paediatric, medical and obstetrical problems. These conditions usually require specialized care based within a community hospital.

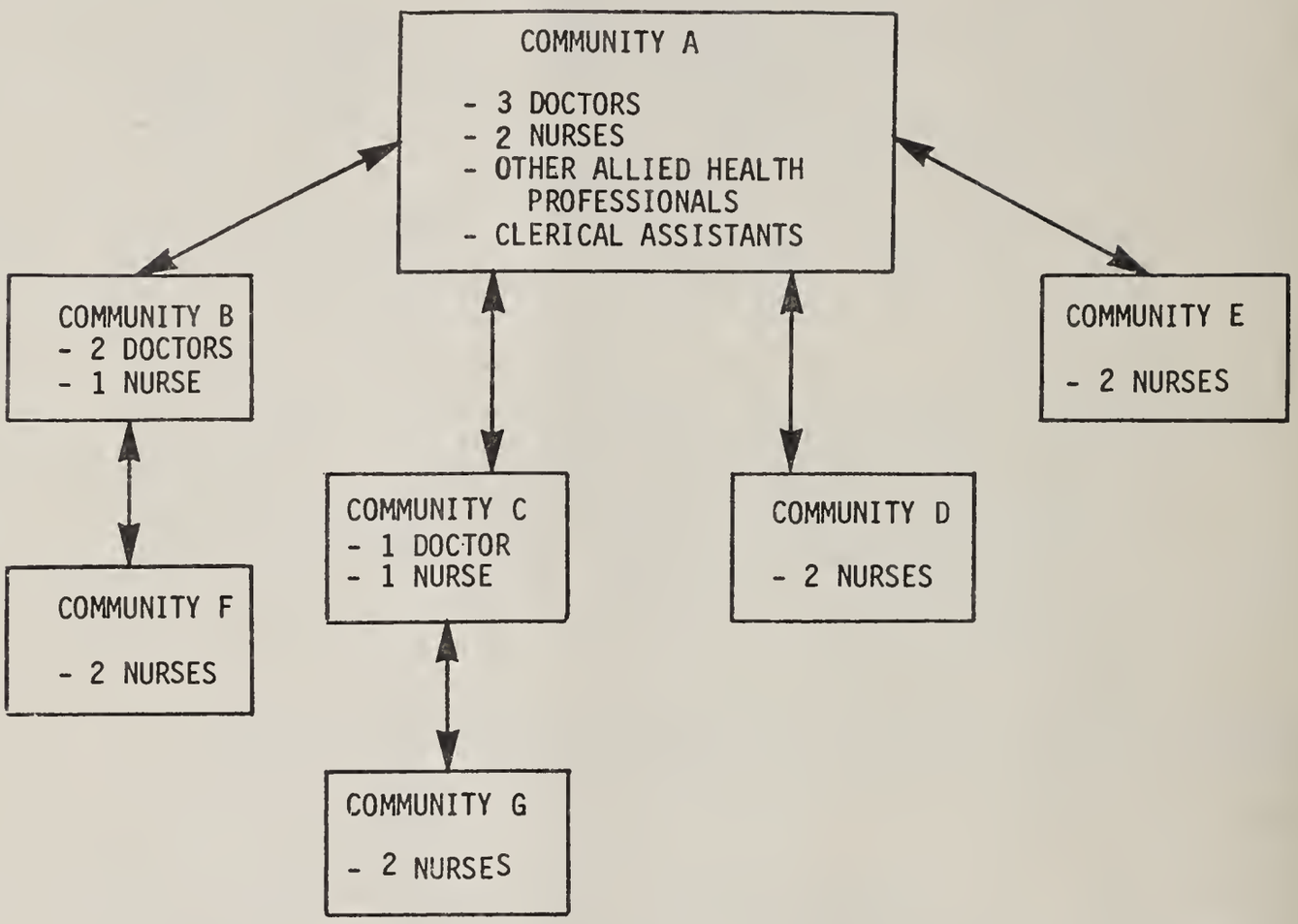
The second category includes unusual inherited disorders, certain forms of cancer, complicated pregnancies, rare metabolic and endocrine disorders, rare and complicated cardio-vascular disorders, catastrophic trauma and complex immunological disorders. Treatment of the problems in this category requires very

10 "The [Community Health Centre Project] Committee sees a community health centre as a facility, or intimately linked group of facilities, enabling individuals and families to obtain initial and continuing health care of high quality." Community Health Centre Project Committee, **The Community Health Centre in Canada**, Report to the Conference of Health Ministers, Ottawa, 1972, p. 1.

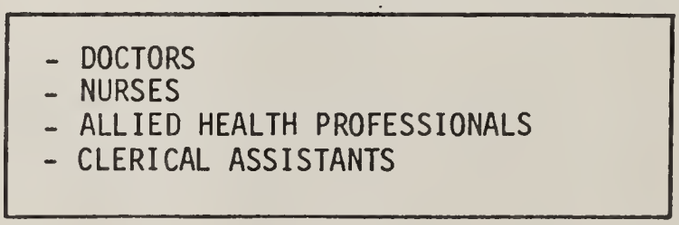
FIGURE 3-1

Primary Health Care Group – Three Examples

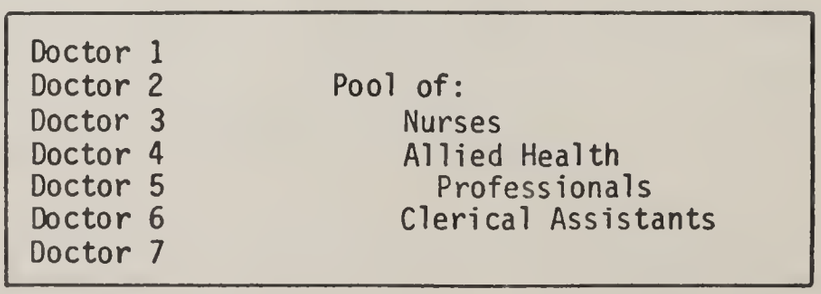
A. ISOLATED COMMUNITY STRUCTURE



B. HEALTH CENTRE STRUCTURE



C. SEPARATED OFFICE STRUCTURE



specialized facilities and professional skills which cannot be placed in all large hospitals. For some conditions, there will be justification for only one or two specialized facilities in the province – for example, facilities for open heart surgery for children and specialized centres for the treatment of rare forms of cancer. The Minister of Health will have to decide in which areas of the province such services are to be provided.

Specialized and very specialized services together constitute the secondary sector. These services need to be coordinated throughout the whole health system to ensure that sufficient resources are available for all levels of health care and to avoid unnecessary duplication. To achieve this coordination, secondary care should be organized according to areas of health care, or programmes. Each area or programme will include both specialized and very specialized services.

Appointments of specialists should be made to all the institutions in the community from which the special services of the programme are provided. It will be the responsibility of each individual physician to ensure that secondary care services are not tied to institutions but apply to the programme throughout the community.

At present, there is little effective coordination of specialized and very specialized care within and between hospitals, and arrangements for coordinating services between primary and secondary care are poorly developed in most parts of the province. Unless effective coordination of secondary care health services is established, we believe that it will be difficult for the Province to make efficient use of its resources to allow for the development of new advances in treatment in this sector.

It should no longer be possible for a hospital to function in competition with similar institutions in the same geographic area. The provision of a satisfactory level of secondary care services should not be impeded by institutional pride (for example, where effective coordination requires reductions in the number of beds provided or the closing down of wings or even of hospitals in certain communities). Furthermore, it should be emphasized that those health problems that can be handled adequately in an ambulatory care setting should not be treated in an in-patient setting. Institutional innovations should be encouraged; they should be allowed in the new arrangement in a form appropriate to the new system.

The secondary care sector has the following responsibilities:

1. Provision of an effective consulting and advisory service for the primary care sector, twenty-four hours a day and seven days a week
2. Development of programmes within a district according to the need for services for special health problems

3. Provision of recommendations to the proposed District Health Council [11]
4. Establishment and operation of an evaluation procedure based on an audit of health services and a review of the performance of health personnel by their peers
5. Provision of recommendations to the proposed District Health Services Advisory Committee [12] concerning manpower requirements for the secondary sector

Patient's Progress Through System

It is useful to follow the progress of a hypothetical patient through the system (this procedure is illustrated in Figure 3-2). The range of services received by the patient and the types of practitioners providing the service will depend on the specific needs of the individual. The system must be sufficiently flexible to meet all the patient's health care requirements.

The patient may go directly to the primary care group or may be referred by a school, a social agency or some other source. Within the primary care group, the first point of professional contact will usually be a nurse or physician.

In most instances, the particular problem for which the consultation is sought will be resolved within the primary care group. In some cases, one visit will be all that is required, while in others, a continuing course of care will be necessary, supervised by the primary care group on an ambulatory basis or in the individual's home. In some more complicated cases, the primary care physician will arrange for the patient's admission to hospital or some other institution and will subsequently oversee the course of treatment in that institution.

If specialist assistance is required, the primary care physician will arrange for this in the secondary care sector. Through the sector's programme structure, the appropriate service, whether specialized or very specialized, will be obtained for the patient.

It should be noted again that the health personnel in the secondary care sector are a resource to primary care. Entry into secondary care will usually be by referral; and in the vast majority of instances, after treatment in the secondary sector, direct care of the patient will be resumed by the primary group.

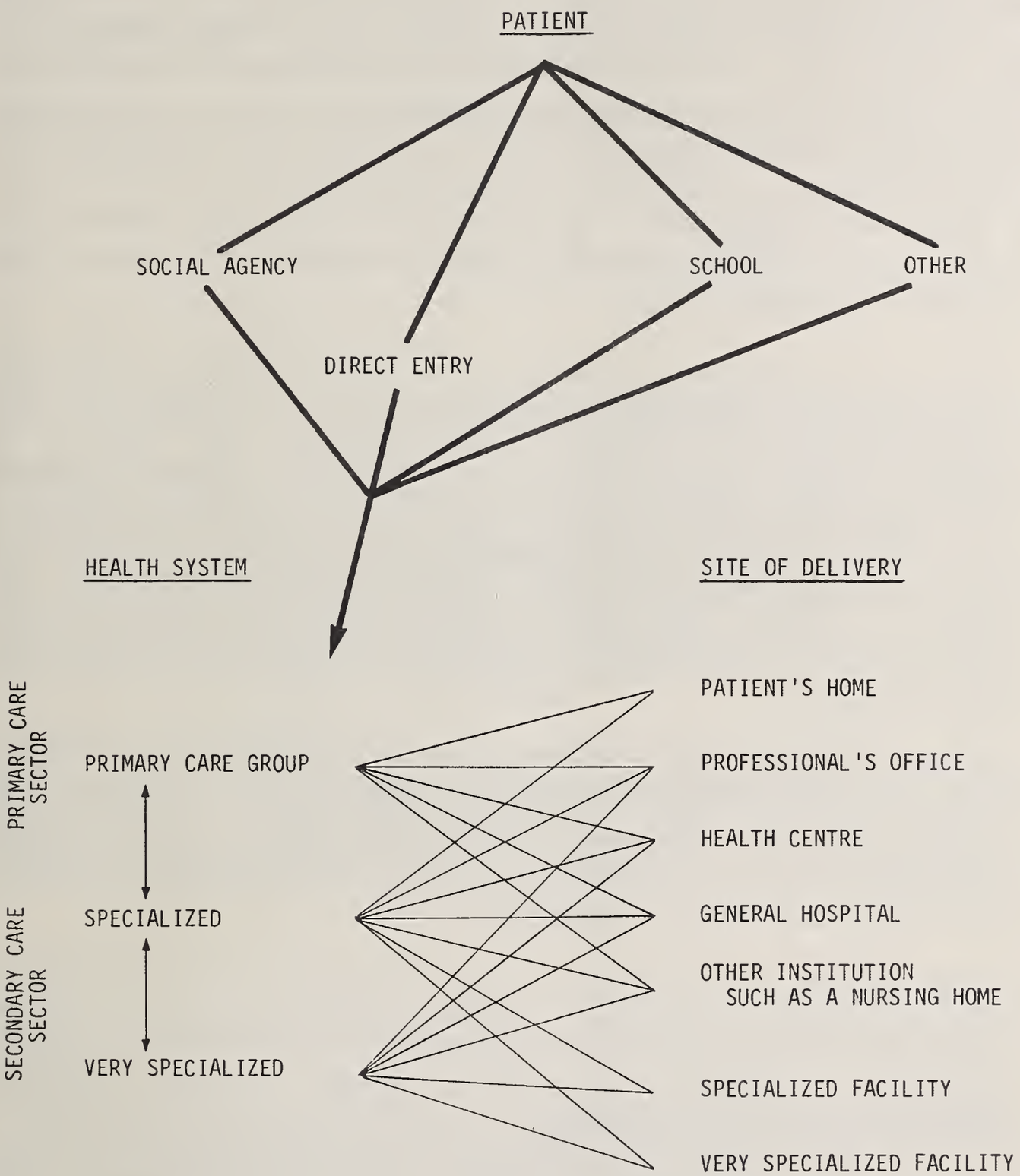
Organization of Primary and Secondary Care

It will be necessary for the members of each primary care group to select from among themselves a Chairman who will provide leadership and will be responsible for coordination and allocation of duties to meet the objective of the primary care

11 See Chapter 4.

12 See Chapter 4.

FIGURE 3-2
Patient's Progress Through System



group. The primary care group will require arrangements for day-to-day administration of its activities, for organizing patients' reception, for establishing and operating a suitable health record system, and for establishing an evaluation procedure of the group's performance by way of an audit of health services and a review of the members' performance by their peers.

Primary and secondary care services will be coordinated throughout the province by district and by area.[13] The Chairmen of all the primary care groups within an area will establish an Area Primary Care Committee to coordinate their activities; and the Chairmen of all the Area Committees within a district will be members of a District Primary Care Committee. Both the Area and the District Committees must include representation from all the major professions in primary care. The District Primary Care Committee will be responsible for ensuring that special services and support services are available to the primary care groups serving the district. It will also have overall responsibility for coordination of primary care services at the district level and will take recommendations for primary care services to the proposed District Health Council.

In the secondary care sector, the personnel in each health specialty or programme will select from among themselves a Chairman to coordinate the programme. These programme Chairmen will establish an Area Secondary Care Committee to coordinate activities throughout the area. The Chairmen of the Area Committees will be members of the District Secondary Care Committee. The District Secondary Care Committee will have overall responsibility for coordination of secondary care services at the district level and will take recommendations from the secondary care sector to the proposed District Health Council. As in the case of primary care, all major professions in the secondary sector must be represented on the Area and District Committees.

A number of diagnostic services, such as laboratory and radiology facilities , should be coordinated within an area and used by both the primary care sector and the secondary care sector. A Chairman and committee for diagnostic services should be established in the area. The Chairmen of the Area Committees should be members of the District Committees for such services.

Quality of Care

The organizational arrangements for the provision of health services must include mechanisms to ensure that the quality of health services is maintained. Responsibility for quality of care must be assumed by participants at all levels in the health care system – by primary care groups, by personnel in secondary programmes, by area and district committees, by the professional licensing colleges and by the Ministry of Health.

13 Our proposal for the organization of services by district and area is detailed in Chapter 4. Districts have geographical boundaries, though these boundaries are not determined by geography alone. Areas comprise sub-units within districts and represent spheres of influence.

The Minister of Health has the ultimate responsibility for the quality of health care in Ontario. The Ministry should coordinate and finance a system of review to that end. This system should have three components – an ongoing evaluation of programmes, a health audit and a peer review procedure.[14]

A method for assessing the health services programmes within each district should be established to evaluate the level of achievement on the basis of previously specified objectives. This procedure should include a measurement of the resources used by each programme. The efficiency of the programmes can be assessed by relating their resource utilization to their achievements.

Hospitals have developed methods of evaluating treatment based on a medical audit of patient records. These procedures should be extended to all health personnel providing health care services in the primary and secondary health care sectors. The principle of the health audit also can be applied to the aggregate performance of health personnel in secondary care programmes and primary care groups. The Chairmen of these programmes or groups will be responsible for taking corrective action where this is deemed necessary.

External peer review of all health personnel directly providing health services to the public should be carried out periodically. For example, the performance of each physician in practice could be reviewed every five years by the College of Physicians and Surgeons. It is important to have lay members on review teams. Each review team should have available to it an assessment by other professionals in the place in which the individual works; the results of the audit of health services; and the results of the individual's OHIP[15] profile. Should this review disclose unsatisfactory performance, it would be the responsibility of the College of Physicians and Surgeons to see that corrective action was taken.

In addition, health professionals in each secondary care programme and each primary care group should establish mechanisms for an internal peer review of all personnel directly providing health services to the public. This review and the effectiveness with which it is carried out will determine the quality of health care provided by the individual groups and programmes.

14 A health audit, like a medical audit, is a method for measuring the quality of care that attempts to overcome the subjectivity of the peer review method. In a health audit, the care rendered (recorded in the chart as having been given) is assessed against a list of standards which is usually drawn up by a committee or a group of peers and which is assumed to represent ideal standards.

Peer review is a method for measuring the quality of patient care by rating the processes of care (for example, as recorded on patients' charts) in a subjective judgement by a peer or group of peers. The peers are usually selected on the basis of their eminence in the field, and the standards they use in judging adequacy are assumed to be ideal standards.

These definitions are based on those given by W.J. Fessel and E.E. Von Brunt, "Assessing Quality of Care from the Medical Record", **New England Journal of Medicine,** Vol. 286, 1972, pp. 134 and 138.

15 Ontario Health Insurance Plan.

Health Records

A uniform system of maintaining health records throughout the province would be a great advantage when records are transferred to another physician or primary care group. It could also facilitate health audits, and ultimately it could provide a very useful tool for health research. We propose that steps be taken to develop and introduce such a standard system on a province-wide basis. This would make possible the computerization of individual health information – a system that may be recommended for its administrative usefulness, provided that the protection of the rights of private individuals can be guaranteed.[16] This system also would permit health professionals to review their practice, with a view to improving the range of services to suit their patients' needs, and would provide health professionals with a mechanism for comparing their performance with each other.

Voluntary Groups

The delivery of health care and of social services has been enhanced by the voluntary effort of private citizens. The diversity of voluntary endeavour in the province by organizations and by individuals is impressive, and its scope is far-reaching. We fully support the continuation of such efforts. Publicly funded services should not do or attempt to do all. Voluntary effort is both an essential ingredient and a vitalizing influence in the delivery of health and social services to the citizens of Ontario. We suggest that voluntary groups should be encouraged to work within the framework of the arrangements of health services proposed in this report.

16 **The Report of the Ontario Council of Health on Health Care Delivery Systems,** Supplement No. 9, The Role of Computers in the Health Field (Toronto, 1970), pp. 26,27.

4 Community Organizational Arrangements for Health Services

To enable the effective planning and operation of the health services system that is described in Chapter 3, suitable organizational arrangements have to be established. Organizational arrangements for districts and areas are considered in this chapter, and those for the Ministry of Health are discussed in Chapter 5.

Organizational Arrangements Within Districts

The principle that there should be local responsibility in planning for health services and in operational activities is already well established in Ontario. Different delivery agencies, however, have different amounts of responsibility and different relationships with the Ministry of Health and local groups. Five examples show some of the differences:

1. Public hospitals are owned and operated by local hospital corporations. Voluntary boards of trustees, composed mostly of laymen, are selected by the corporation members; the Lieutenant Governor in Council also may appoint representatives to hospital boards. Boards may plan for additional buildings or facilities, but the plans must be approved by the Minister of Health before construction can proceed. Hospital planning councils and coordinating committees for health sciences complexes [1] are now operating in many areas of the province. A large number of the projects undertaken in recent years have been reviewed by these planning councils before approval to proceed has been given by the Ministry.

   The Province provides most of the capital costs for approved hospital projects (66 2/3 per cent to 100 per cent), with the community being responsible for the remainder. The Province pays for operating costs for patients insured under the Ontario Health Insurance Plan. The provincial contribution averages approximately 90 per cent of operating costs with the remainder being met by other agencies such as the federal government, the uninsured patient and the hospital. Hospital boards are accountable to the Ministry for the spending of these funds. They are also responsible for managing the facility and maintaining quality of care.

1 A health sciences complex is a total unit composed of a university health sciences centre together with any college of applied arts and technology or other institutions involved in the production of health manpower within the sphere of influence of a particular centre. A university health sciences centre is a health sciences development on campus and related developments, including hospitals.

2. Public health services are provided by local boards of health. These boards are autonomous, with the majority of board members appointed by the municipalities (including regional government) in the areas covered by the health units. The remaining members are appointed by the Lieutenant Governor in Council on the recommendation of the Minister of Health.[2] The provincial government provides financial support (25 per cent to 75 per cent of costs) for approved services, and the municipalities are responsible for the remainder. Municipal governments pay the full cost of services that are not provincially supported (such as dental treatment services). When boards of health undertake programmes on behalf of the Province (for example, home care), the Province pays the full cost of the programme. Responsibility rests with the board, and the board is financially accountable to both the municipal governments and the Ministry of Health.

3. Provincial psychiatric hospitals are owned and operated by the provincial government. Day-to-day administrative responsibility is delegated to the hospital administrator. The Province is giving consideration to the establishment of community boards which will have responsibility for operating these institutions similar to boards for public general hospitals.

4. Nursing homes are privately owned and operated. They are licensed by the Ministry of Health and may not be built or renovated without Ministry approval. No provincial grants are available to meet capital costs. Services are contracted and payment is made by the Ministry, at a per diem rate, for patients in need of extended care. Nursing homes are inspected by Ministry staff to ensure that the standards are adhered to.

5. Most physicians and some other health professionals (such as optometrists, chiropractors and some physiotherapists) receive payments from the Ontario Health Insurance Plan directly and not through an institution. The Ministry pays for services provided to the patient by the practitioner in accordance with an agreed schedule of benefits.

These present organizational arrangements will not readily allow the development of the comprehensive health services system proposed in the preceding chapter. Since this system requires that resources be allocated according to broad need assessed on a province-wide basis, the government must assume a major role in the process of planning for services and in determining overall priorities. We believe that what is required is a new type and level of planning – comprehensive planning for all health services on a district-wide basis. We also believe that new arrangements are required for operational activities on an area basis within districts.

2 Where municipal boards of health instead of health units exist (five are in operation in the province, in Metropolitan Toronto), no members are appointed by the Lieutenant Governor in Council.

Proposed District Plan

A set of proposed health districts has been delineated, taking into consideration factors such as population, transportation patterns, distribution and referral patterns of health and other related services (for example, those of the Ministry of Community and Social Services), areas of responsibility of existing boards (such as boards of health), local community identification related to district and regional centres, and other boundaries of regional government or related service and/or planning bodies (such as the Ministry of Community and Social Services). Since one aim is to develop coordinated health and social services, the boundaries for these services are as closely matched as possible. These proposed health district boundaries are shown in Map 4-1.

We believe that these districts should be used as a basis for the establishment of District Health Councils. Experience may indicate that modification is required in certain instances, but these districts will provide a base from which an immediate start can be made.

Metropolitan Toronto is too large to be considered as a district. One arrangement might be to classify it as a region containing a number of District Health Councils.

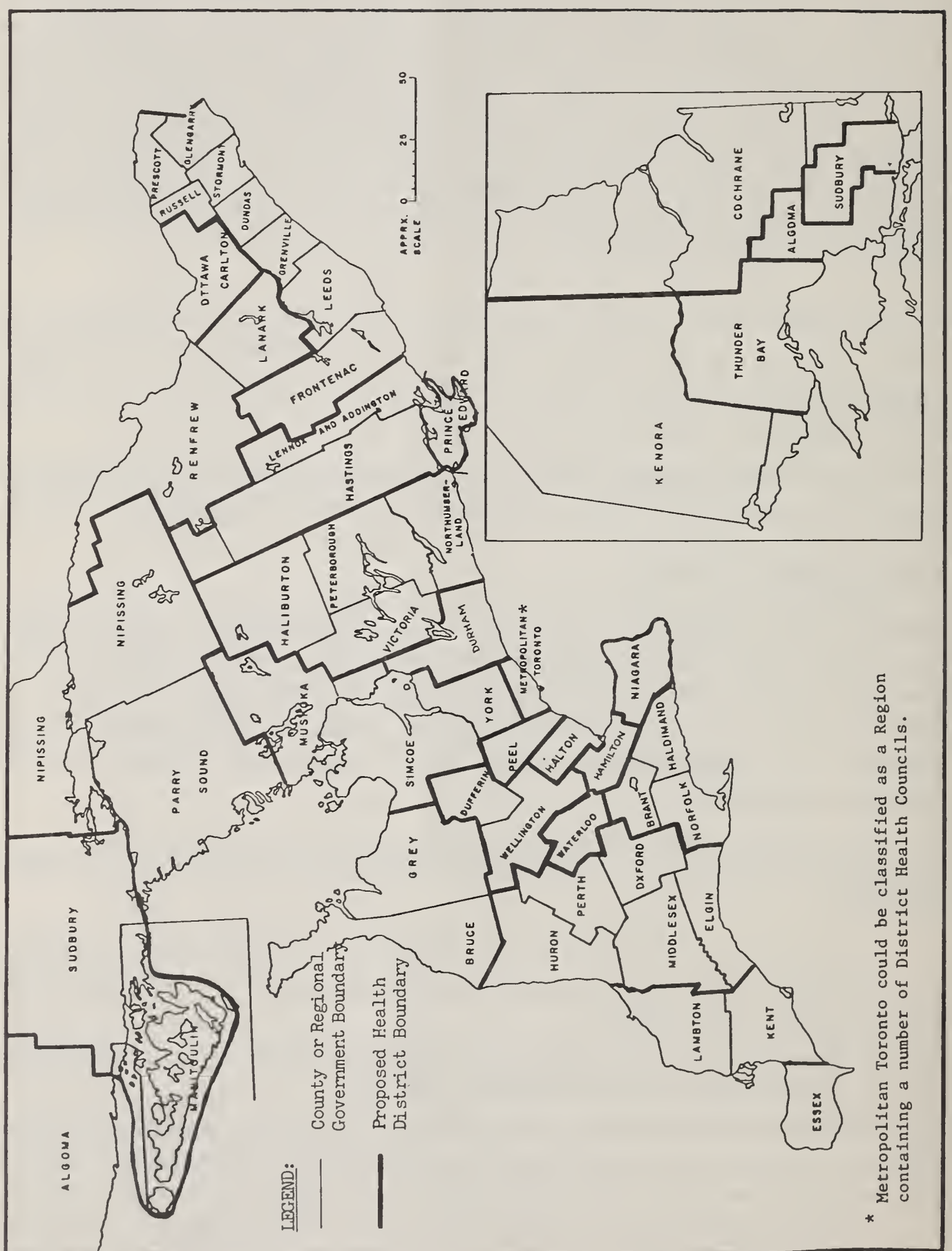
District Health Councils

Because of the urgent need for a new health services system, District Health Councils should be established by statute as rapidly as possible throughout the province. Each Council should be responsible for the development of policies and plans for the delivery of health care within its district. The Councils should undertake their responsibilities within the framework of provincial policies, guidelines and standards.

The specific responsibilities of District Health Councils are described in more detail as follows:

1. Providing leadership for and ensuring the development of coordinated health care groups and programmes in the primary and secondary care sectors in the district.
2. Developing, assisting with and recommending plans for the establishment of Area Health Services Management Boards.
3. Planning for the district a coordinated spectrum of programmes in the primary and secondary care sectors and planning the development of both public and private facilities. This would involve establishing objectives; identifying needs, evaluating alternatives and establishing priorities as to how existing needs could best be met to ensure the most effective use of resources. Recommendations would be made to the Ministry concerning the introduction, modification or termination of programmes within the

MAP 4-1
Proposed Health Districts



primary and secondary care sectors; the construction, renovation or closing of facilities; and the selection of sites for the delivery of services. For planning within the district to be effective, the Ministry must not give approval for changes in programmes or sites of delivery of service, whether initiated locally or by the Ministry, unless it has received a recommendation related to the change from the District Health Council.

4. Establishing, within Ministry guidelines, the professional manpower requirements for health services in the district and ensuring that the positions that are filled satisfy these requirements. Payment of a practitioner under the Ontario Health Insurance Plan would depend upon the practitioner's filling an approved position within the district. If no vacancies were available in a district at a given time, a physician might set up a practice, but he/she would not be eligible for OHIP registration.
5. Ensuring that methods exist in the district for effective and appropriate evaluation of health services and that suitable arrangements exist for taking corrective action when required. This would include ensuring that quality of care was maintained and that effective mechanisms were established for internal and external audit of health services and for internal and external peer review of health professionals.
6. Making arrangements with other District Health Councils to facilitate the provision of specialized and very specialized services not available in a particular district.
7. Facilitating coordination between health and social services in the district. This would involve establishment of linkages between public, private and voluntary organizations and agencies to ensure that the individual would be able to receive the care needed, in either the health system or the social services system.
8. Encouraging the use of facilities for the clinical education of health personnel, and coordinating their availability for this purpose throughout the district.
9. Establishing an effective information system to supply data on community needs and to draw on health services information compiled at the Ministry level. The Council must have access to such information as it needs to carry out its functions.

It is intended that the District Health Council should have the authority for health care services planning and policy in its geographic area. It would not have the power to authorize expenditures, since the tax base is at the provincial level. It should not become involved in matters of detail that could be settled at other levels – for example, by the Area Health Services Management Board, by institutions or by the primary care group or the secondary care sector.

At this stage in the development of the health services system, we believe that responsibility for planning should be separated from responsibility for operations.

Under ideal circumstances, and if the system were in need of less major restructuring, this separation should not necessarily exist. Separation of planning and operations is required now because there is an immediate need to develop total integrated district plans for health services, reflecting the new direction of the health system. This process should not be hampered by the responsibilities for ongoing operational activities. There is also the need to avoid the conflict that could arise from the Council's planning for expansion in one part of the system while being held accountable for operations in another.

The relationship between the provincial government and the District Health Councils is crucial. It should be made clear that no recommendation pertaining to health services in a given district will even be considered by the provincial government unless a recommendation related to the proposal has been put forward to the Ministry by the District Health Council involved. We are concerned that the background lobbying and pressure group tactics that are characteristic in many jurisdictions should not impede or distort the use of proper decision-making processes in meeting Ontario's health care requirements.

Council Membership

District Health Councils should consist of ten impartial members appointed by the Lieutenant Governor in Council on the advice of the Minister of Health, from lists of nominees submitted by interested organizations and individuals in the district, plus up to five representatives of municipal governments in the district. No one municipality should have more than two local government appointees. Members should hold office for a three-year term, renewable once, with one-third of the members retiring each year (initial terms of office should be set to make this feasible). The Chairman should be appointed by the Lieutenant Governor in Council for a five-year term, renewable once. Nominations to fill vacancies should be obtained from nominating committees established by the Council. Members should not be paid but should be reimbursed for their expenses.

Council Staff

District Health Councils will require staff to assist them and their committees in carrying out their responsibilities. Some of these may become available from existing institutions in the district. A secretariat should be formed, consisting of a senior officer and a small staff. The Council also should be empowered to call on other resources, such as consultants and the staff of the Ministry of Health. Sufficient funds will have to be provided for these purposes.

Supporting Committees

District Health Councils will require committees to assist them in carrying out their responsibilities. The details of the committee structure should be decided by each District Health Council according to its particular needs.

To achieve integration and coordination of services at the local level, it is essential that both health professionals and administrative personnel take part in the decision-making related to their areas of work. Because of the personal nature of health services, health professionals must be responsible for recommending, through the district organization, the scope and quality of health service to be provided. Failure to involve health professionals in the decisions regarding health services could lead to loss of their commitment and interest, with serious consequences in terms of the quality of health services provided. To ensure the involvement of health professionals in the district programmes, a District Health Services Advisory Committee must be established.

The District Health Services Advisory Committee should have the following functions:

1. Recommending to the District Health Council changes in the health services programmes in the district
2. Assisting in the establishment of approved programmes
3. Acting for the District Health Council to ensure effective coordination and communication between primary and secondary care
4. Acting for the District Health Council to ensure that quality of care is maintained, and developing mechanisms for audit of health services and peer review of health professionals
5. Facilitating coordination between health and social services at the delivery level
6. Providing advice to the District Health Council in respect to the manpower required for health services in the district

The members of the District Health Services Advisory Committee should be drawn from health personnel in the primary and secondary care sectors. They should include the Chairman of the District Primary Care Committee, the Chairman of the District Secondary Care Committee, the Chairman of the District Committee for diagnostic services and the Chairmen of all Area Health Services Advisory Committees.[3] Additional members from the primary care sector and from the secondary care sector should be selected so as to ensure balanced participation by the major health professional groups. The Chairman of the District Health Services Advisory Committee should be appointed by the District Health Council.

The District Health Council may, in addition, need to establish committees to assist it in the following four areas:

1. **Planning.** While the main function of the District Health Council is overall planning for the district, it may be necessary to form a committee to give preliminary consideration to the plans proposed by the District Health Services Advisory Committee, by Area Health Services Management

3 Described on p. 35.

Boards [4] and by institutions. Such a group could also be called on to study the long-term needs of the district.

2. **Facilities.** Another group might be established with responsibilities related to the health facilities available within the district. They could recommend to the District Health Council changes in the use of facilities and the consolidation of facilities such as laundry services. They could study the possibilities of reallocating services among institutions to make better use of existing facilities and select the most suitable physical location for proposed new facilities.

3. **Education.** The health care resources within the district will be used in the clinical education of health personnel. In addition, the district should be able to draw on the resources of the district's educational institutions for programmes of public education in health and continuing education for health professionals. A committee [5] to coordinate the use of resources for education could be useful to the District Health Council.

4. **Community Relations.** The District Health Council should establish procedures suitable to the district for obtaining the views of the local people and passing on to them for discussion proposals for future health services.

We note in passing that the local transportation network is a key factor in any discussion of the location of health facilities. As we have emphasized, the public must have access to services, according to the principles outlined in Chapter 2 of this report. In certain areas, substantial savings in capital costs might be effected and duplication of health services could be avoided if transportation costs were paid to assist patients in reaching the available facilities. A detailed study should be carried out by the Ministry in consultation with the District Health Councils to see if this would be feasible and to suggest suitable guidelines.

With the development of District Health Councils and their committee structures, present hospital planning councils will be phased out and their activities included in the broader activities of District Health Councils.

Role of the Ontario Hospital Association

With the reorientation of the health services system that is proposed, it will be necessary that the functions of the Ontario Hospital Association be re-examined. Among its present activities, the Association sponsors educational programmes, operates pension plans and operates the Blue Cross Insurance Plan; it also represents the interests of hospitals and provides advice to the Ministry of Health on hospital matters. In the future, the need for the Association to perform this last

4 These are discussed later in this chapter.

5 This committee could be developed in relation to the Health Sciences Coordinating Committees considered on pp. 68-69.

role will not exist, since such advice will be offered by the District Health Councils. The government and the Association should jointly re-examine the functions of the OHA in the light of our proposals. If the Association is to have a role in the future, this role must be compatible with the new system.

Councils and Regional Governments

We suggest further that the authority for health planning and/or operational activities should not be assigned, at this time, to regional government. There are a number of reasons for this recommendation. Because there is a need to ensure that the health services system change direction quickly and efficiently, the Ministry of Health must initially take the lead in and assume responsibility for planning and redirecting the system. In addition, with the need for constraints on rising costs and considering the extent of proposed changes in the system, overall control must lie with the Ministry.

The Ministry has recently assumed responsibility for duties previously carried out by the Ontario Hospital Services Commission. Integration with its other activities is now being developed. The Ministry must guide the system in the developmental stages. It is essential also that there be maximum linkage and consistency between provincial and district planning levels. This requires that the Ministry be ultimately responsible for the planning process.

Transfer of either authority or advisory reporting relationships to regional governments also would be unwise under present circumstances. Areas covered by regional governments are not necessarily appropriate areas for planning of local health care. In addition, each regional government is at a different level of development and each has varying capabilities and priorities for future growth. The variances in internal committees and administrative structures and arrangements do not necessarily lend themselves to the requirements of health planning. In this context, it would be difficult for the Province to ensure, as it must, that basic standards are adopted uniformly throughout Ontario.

At present, the exact role of regional government now and in the future has not been finally determined in respect to such areas as planning, delivery of services, form of accountability to the Province, nature of accountability and relationships to operating Ministries. This fact should not be permitted to delay the planning and development of the proposed health services system. The proposals we have set forth do not in any way hinder or exclude a future transfer of authority to regional government. But to initiate the proposed changes now through regional government which itself is undergoing change would lead to enormous difficulties. The changes needed to achieve a balanced health system in the province will require concentrated attention. If this effort is distracted and confused by being implemented through another area of major change, we believe chaos could develop in the health system.

Moreover, if regional government were to assume complete responsibility for health services, the arrangement would have to include responsibility for the payment of health professionals. We believe it would be impractical to introduce a system of payment for health professionals on a regional basis at this time.

Councils and Social and Community Services

There must be close cooperation and coordination between local government and District Health Councils in planning for new facilities in health services, social services and community services. Social services play an important role in the continuum of care for the individual. It is important that social and community services be involved in the planning for health services, in order to prevent duplication at the local level and to make the best use of available resources. This would be possible through representation in the committee structure of the District Health Council and on social and community services committees. The details of the arrangements should be decided locally; we believe, however, that it will be necessary for District Health Councils to meet with each voluntary agency in health and social services in order to work out ways in which their services can be continued or modified to fit the new concepts of comprehensive health care.

Ultimately, it may be possible to provide for the complete coordination of health, community and social services at the district level.

Provincial Foundations and Health Institutes

There are a number of foundations and/or institutions which have been given province-wide responsibility. Among these are the Alcoholism and Drug Addiction Research Foundation, the Ontario Mental Health Foundation and the Ontario Cancer Treatment and Research Foundation. Some of these bodies are associated with provincial institutions, such as the Princess Margaret Hospital, the Ontario Cancer Institute and the Clinical Institute of the Alcoholism and Drug Addiction Research Foundation. For each institution, there is a special Act of the Legislature that sets out its responsibilities.

The personal health services provided by these bodies at the local level must be provided through the mechanisms established by the District Health Councils. The provincial institutions must be a resource to the health services system throughout the province.

Area Health Services Management Boards

In order to provide for the integrated delivery of health care in a given area, it is proposed that Area Health Services Management Boards be created and established by statute. The responsibilities of an Area Health Services Management Board should be decided on the basis of the logical grouping of facilities and administrative resources, rather than solely geographic considerations. These responsibilities should include:

1. Managing health services institutions in accordance with defined statutory responsibilities assigned to it
2. Providing an administrative base and leadership for the development of primary and secondary health care services within the area
3. Recommending short-term and long-term plans for facilities and health services to the District Health Council
4. Implementing approved plans according to the policies and objectives established by the District Health Council
5. In collaboration with the District Health Council through an Area Health Services Advisory Committee, implementing and maintaining mechanisms for the evaluation of health services by means of an audit of health services and a review of the performance of health professionals by their peers

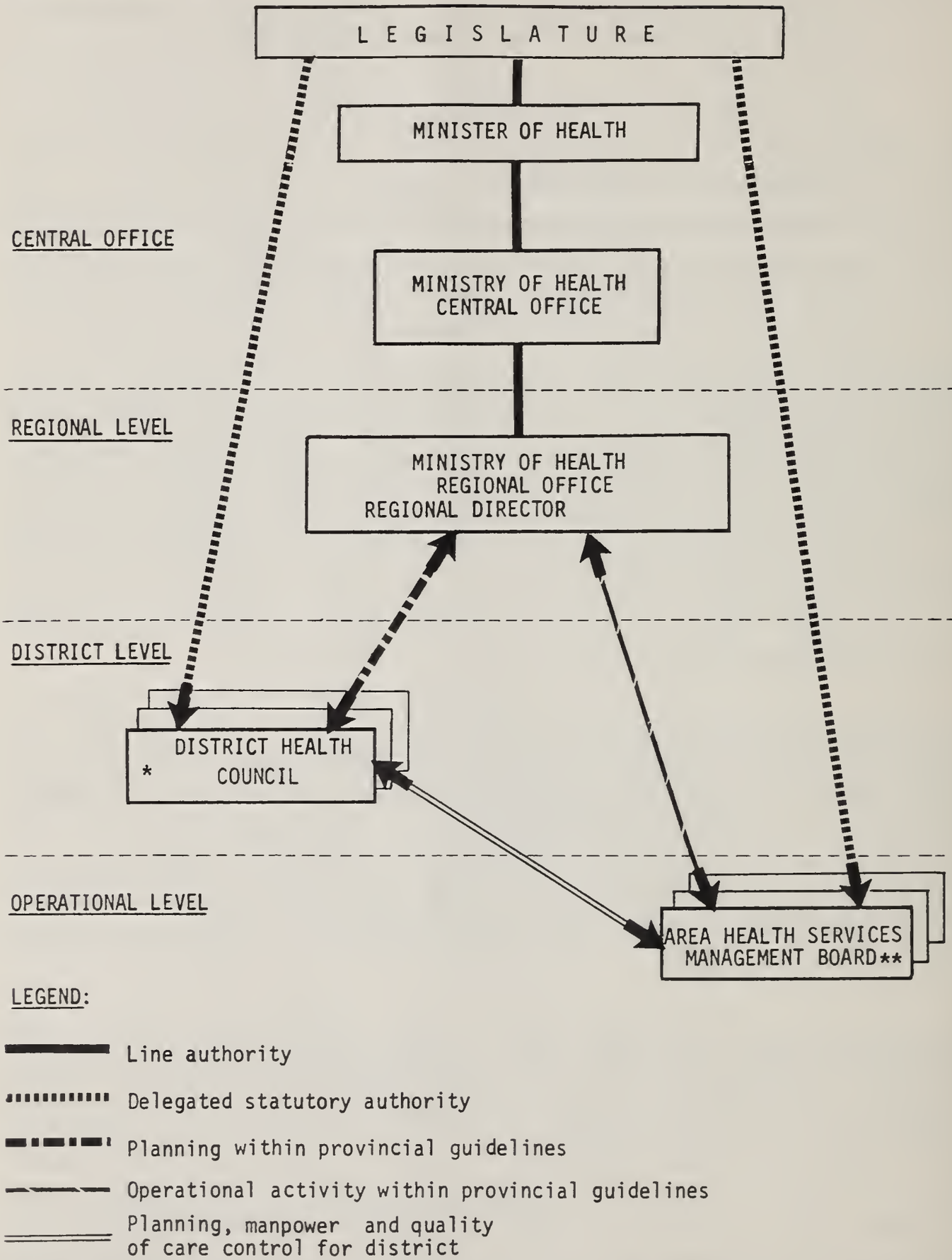
Boards may be formed in various ways, depending upon the local situation. Where a District Health Council exists, the Council should recommend the establishment of Area Health Services Management Boards. This is not to say, however, that District Health Councils are a necessary prerequisite to the creation of Boards. If a District Health Council has not yet been formed, other groups and existing health services boards could be organized to establish Area Boards. Thus, for example, the boards of hospitals and their administrative resources could provide the nucleus for forming a Board. With the establishment of the Board, the responsibilities of the health services institutions in the area would be turned over to it.

A variety of arrangements might exist throughout the province for some time, with some institutions continuing to function individually and some institutions consolidating on an area basis. Ultimately, privately owned and operated facilities such as private hospitals and nursing homes also might come under the responsibilities of Area Health Services Management Boards. It must be emphasized that the activities of all institutions throughout a district must be coordinated within the framework of the district plan, whether or not these institutions are managed by an Area Board.

As noted, present hospital boards could form the nucleus of Area Health Services Management Boards. Hospitals already contain administrative ingredients that are essential to the operation of the health system. These include a medical organization to coordinate the work of physicians, an administrative organization that enables the health professionals to carry out their duties, and a Board of Trustees which is charged with overall responsibility for management of the institution. Many hospitals now focus on a narrow part of the secondary care sector, but some hospital boards would welcome the challenge of an expanded role. If a board chooses such a role and if it is considered appropriate, the board must be augmented with new members from the community to ensure that the health care system has a community focus.

Boards should be advised by an Area Health Services Advisory Committee.

FIGURE 4-1
Proposed Organizational Arrangements for Health Services



*Overall planning for the district, recommending to the Ministry, changes in programme, facility, and site of delivery; defining manpower requirements and monitoring quality of care in the district.

**Operational activities for the area including managing the institutions, developing mechanisms to ensure quality of care, implementing planning recommendations approved by the Ministry, facilitating the coordination of primary and secondary care, and providing administrative support to primary care groups.

Members would be drawn from the health professionals in the primary and secondary care sectors, with a balanced representation of the major health professional groups. The Chairman of the Area Primary Care Committee and the Chairman of the Area Secondary Care Committee also must be members of the Area Health Services Advisory Committee.

The establishment of Area Health Services Advisory Committees should not be dependent upon the pre-existence of Area Health Services Management Boards; that is, the absence of a Board in a certain area should not preclude the development of an advisory structure at the area level. This proviso is important to ensure area representation on District Advisory Committees.

The relationships between the Area Health Services Management Board, [6] the District Health Council and the Ministry of Health are illustrated in Figure 4-1. Their respective functions can be summarized as follows. The District Health Council will be responsible for planning, within Ministry of Health guidelines. The Area Health Services Management Boards will collaborate in this. Recommendations from the District Health Council will go to the Regional Director for Health Services.[7] When planning decisions are taken by the Ministry, the decisions will go from the Regional Director to the appropriate Area Health Services Management Board for implementation and to the District Health Council for information. The Regional Director will have sufficient authority delegated from the Minister through the Deputy Minister to decide on as many recommendations as possible at the regional level. With respect to ongoing operational matters, the Regional Director and his staff will deal directly with the Area Health Services Management Boards. They will assist Boards in carrying out their responsibilities within the established guidelines; the Boards, however, will be fully accountable to the Ministry through the Regional Director for use of the funds provided. The District Health Council will not be involved in the detail of institutional operations.

Public Health

The plan proposed in this report necessitates a reappraisal of public health services. In order to attain the goal of an integrated, comprehensive health service, those elements of personal health care currently provided by local Departments of Health should become part of the primary health care sector.

Personal health care services are services (including promotion and maintenance of health) provided to families and individuals in the community extending from the prenatal period to old age and embracing many human and environmental factors

6 Where Area Health Services Management Boards are not in operation, existing institutions will relate to the District Health Council and the Ministry of Health in the manner described here.

7 This is a new position that we are proposing within the Ministry of Health. The role and responsibilities of this official are detailed in Chapter 5.

that affect the individual, the family and the community. At present, these services are provided mainly by public health nurses.

Existing public health services have developed valuable working relationships with local government and community agencies, both official and voluntary, as well as with groups in the community. During the period of transition, it will be essential to ensure that these interdependent local working relationships continue and that there is no interruption of service to particular groups, families and individuals in the community.

School health programmes, traditionally a service provided by local Departments of Health, should be carried out by primary care groups in cooperation with the Boards of Education. A particular and very important aspect of this programme includes child guidance, which involves health, education and community and social services. Effective communication and coordination of these services in both the community and the school system is essential, in order that the services are accessible and available without long delay.

If the principle of integration is accepted, then obviously the local Board of Health will cease to be concerned directly with personal health services. We suggest that the Board of Health should have primary responsibility for environmental health, at the local government/health district level. This responsibility will include the public health aspects of environment conditions at place of work and in the home. It will also relate to food safety and diseases of animals insofar as they affect human health.

The Board of Health will continue to have a responsibility in communicable disease control (other than epidemiology, immunization and treatment), particularly in respect to food and water-borne disease. As far as health information is concerned, the Board of Health will retain the responsibility for making available information about matters such as food safety and the public health aspects of the environment. These functions should be integrated with the public health education activity of the District Health Council.

In the light of these proposed changes, the present fiscal responsibilities of the Province and local government in these matters must be revised. There is need to re-examine the place of occupational health within these new arrangements and to link this with a new thrust in relation to environmental health.

In addition, the future responsibility of the Medical Officer of Health should be assessed. He or she could assume the role of district advisor in community health, comparable to the district advisory position that is now being introduced in the reorganized National Health Service in Britain. The Ministry of Health should give early consideration to this proposed redirection in responsibility of the Medical Officer of Health.

Finally, it must be recognized that the public health nurse has a leadership role to

play in the area of primary care. With a very broad knowledge of health problems and ability to work with the other community, social and education services, the public health nurse is one of the keys to the successful development of this sector of the health services system.

Concluding Comment

The District Health Councils and Area Health Services Management Boards that we have proposed in this chapter can provide the mechanisms needed for effective planning of health services and for efficient and economic delivery at the local level.

District Health Councils have been recommended by many of the reports we have reviewed.[8] What is new in our proposals, however, is the scope of the functions defined for these Councils and for the Area Health Services Management Boards, and their relationships with local operating agencies in the health field, with voluntary agencies and with the social services network.

8 The Royal Commission on Health Services felt that regional and local Health Planning Councils should be established. **Report of the Royal Commission on Health Services** (Ottawa: Queen's Printer, 1965), p. 231.

The Ontario Council of Health has recommended the development of District Councils. Ontario Council of Health, Regional Organization of Health Services (Toronto, 1969), Annex "A", p.12.

The Committee on the Healing Arts stated that there was a place for some type of regional organization for health services in the province and supported the recommendation concerning District Councils made by the Ontario Council of Health. **Report of the Committee on the Healing Arts** (Toronto: Queen's Printer, 1970), Vol. 3, pp. 23-26.

The Joint Position Paper on District Health Councils by the Ontario Hospital Association and the Ontario Medical Association (May 1, 1973) supports the development of District Health Councils.

It should be noted, however, that although all these documents recommend or endorse the development of District Health Councils or other local collaborative arrangements, the concepts of the scope of responsibility and authority differ.

5 Organization Structure for the Ministry of Health

The organizational arrangements that we have proposed at the community level require the restructuring of some functions of the Ministry of Health. In this chapter, we shall describe the structure that would best facilitate the planning and operation of a comprehensive health care system.

Present Organization

The structure of the Ministry prior to the fall of 1972 need not concern us here. It should be noted, however, that on August 22, 1972, there was issued a document entitled **An Implementation Plan for the New Orientation and Structure of the Ministry of Health.** This was followed on January 12, 1973, by a second document entitled **The Implementation of the New Orientation and Structure of the Ministry of Health.**

The principles behind the then proposed, and now actual, organization were stated as follows:

1. All health needs will be served by one comprehensive program.
2. The responsibility for health care will be shared by the Ministry and District Health Councils.
3. The public will be strongly represented on the District Health Councils, and will participate in the development of district programs.
4. Greater responsibility and accountability for health care will be shifted to the community.

   The concept of one comprehensive health care program will relate all areas of special interest to the changing needs and priorities. Three primary functions – setting standards, ensuring the delivery of services, and financial management – replace the three major program areas as the basis for the organization of the Ministry.

   Planning becomes a co-ordinated effort within the Ministry, and at the District level, in relation to needs and priorities. New services will be considered in the context of the total effort required to develop and maintain a balanced program. Evaluations will be possible in terms of the overall benefits provided to the population served.

   Managerial responsibilities for the delivery of services will be clearly separated from the technical responsibilities for setting standards for health care.

   The responsibility for providing services to meet local needs and

conditions will be shared with District Health Councils. The public will have a strong voice in the development of local programs, through representation on the District Health Councils.[1]

The Implementation Plan noted that the high degree of specialization in health care has increased the tendency towards fragmentation of services "to a degree that interferes with the effective use of available resources".[2] Furthermore, planning has tended to occur more or less independently within separate programme areas (such as health promotion and disease prevention, treatment and rehabilitation, and psychiatric and retardation services) "rather than in the context of an overall health care program".[3]

Briefly, the two main proposals of the Plan were

1. To reorganize the Ministry of Health to eliminate separate compartments, to effect decentralization and to make it possible for all decisions to be made within the context of an overall programme area
2. To create District Health Councils as an essential ingredient of local partnership to achieve the same aims

The formation of District Health Councils has, however, been delayed, and as a result the Ministry's detailed planning has been hindered.

The Implementation Plan saw all activities within the Ministry as relating to three primary areas of responsibility:

1. Development of standards, provision of consultant services and evaluation of programmes
2. Delivery of health care services
3. Administration of the Ministry

These three primary areas of responsibility were allocated respectively to the Health Standards Group, the Health Services Group and the Finance and Information Services Group. Each was placed under the direction of an Assistant Deputy Minister.

The **Health Standards Group** was seen to be responsible for

1. The development of provincial standards and guidelines for the comprehensive health care programme
2. Evaluation services
3. Professional and technical advisory services

1 Ontario Ministry of Health, **An Implementation Plan for the New Orientation and Structure of the Ministry**, August 22, 1972, pp.2-3.

2 **Ibid.**, p. 2.

3 **Ibid.**

The **Health Services Group** was seen to be responsible for

1. Implementation of the comprehensive health care programme through District Health Councils
2. Maintaining close and effective relationships with District Health Councils
3. Carrying out present responsibilities for direct services (the principle was clearly enunciated that the government would work out a plan over an unspecified period of time to relieve itself of existing responsibilities for direct services)

The **Finance and Information Services Group** was seen to be responsible for

1. Financial services
2. The Ministry of Health information system
3. Health insurance
4. Other support services

Other elements of the Ministry organization include the Legal Branch, the Personnel Branch and the Communications Branch, each of which reports directly to the Deputy Minister. Figure 5-1 shows the present organization structure and lines of authority between the various branches and divisions.

To provide for the coordination and integration of Ministry activities, the Implementation Plan proposed the establishment of three senior management committees. The Health Strategy Committee, composed of the Minister, the Deputy Minister and the three Assistant Deputy Ministers, would set the overall direction and objectives of the health care system, in response to the needs of the population. The Health Program Committee, composed of the Deputy and Assistant Deputy Ministers, would be responsible for decisions concerning programme development, priorities and expenditures. In performing its role, the Program Committee would draw on proposals and recommendations from Ministry groups and task forces and from institutions, groups and individuals outside the Ministry. The third committee, the Ministry Administration Committee, would give direction to the day-to-day operation and management of the Ministry.

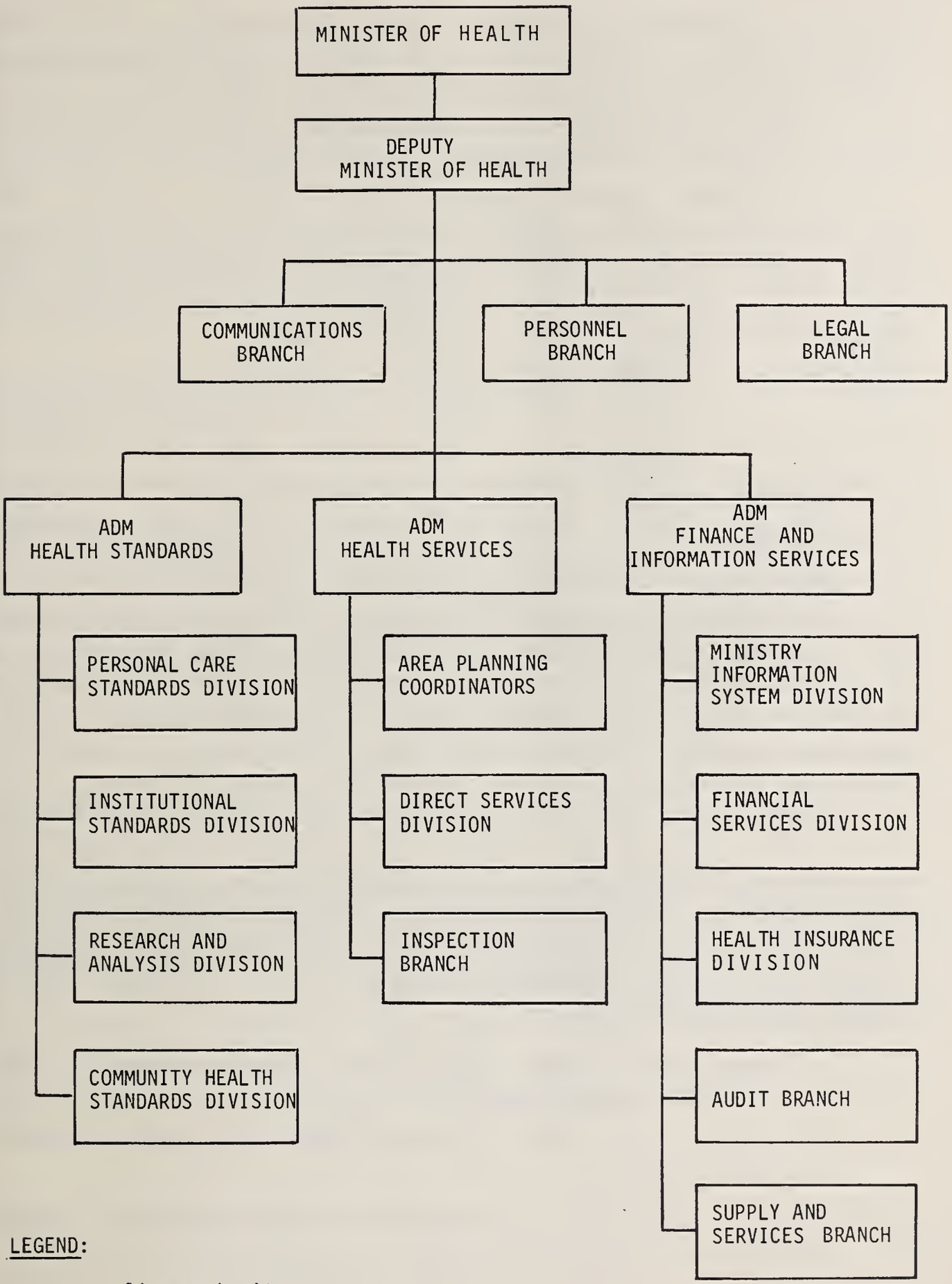
The Plan also proposed that a Secretariat be established whose main task would be to coordinate the development of policy proposals and assist in the preparation of submissions for the social policy field.

The Ministry uses these mechanisms for the selection and evaluation of proposals for new arrangements in the health care system, so that such proposals may be incorporated into policy decisions.

Proposed Regional Office Structure

District Health Councils could operate under the present Ministry of Health structure, but in our opinion further improvements must be made to achieve

FIGURE 5-1
Ministry of Health Present Organization Structure (January 1974)



optimal use of the Councils and to permit full implementation of our proposals for the health system. The key to the new structure is the establishment of a system of regional offices to serve the districts throughout the province.

The Ministry reorganization plan rightly saw that the relationships between the Ministry and the District Health Councils were "the critical points of contact within the total health care system".[4] The Implementation Plan stated that "at this point, the District Health Council Programs, developed within Ministry guidelines, but tailored to meet the needs of the public within the District, must integrate with the Provincial Health Programs developed by the Ministry."[5] Moreover, "the major responsibility for this integration and for continuous, effective interface between the Ministry and the District Health Council"[6] lay with an official of the Ministry called the Area Planning Co-ordinator, who would constitute the important, ongoing contact between central and local levels.

Although the Plan clearly recognized the need for close liaison between the Ministry and the District Health Councils, it failed to provide a satisfactory mechanism for this relationship to develop as fully as it must. We believe that an essential factor in the effective planning and operation of the health care system is the presence of a Ministry official in or near each district who is physically accessible to the Council and who, by virtue of his proximity, has an understanding of the district's needs. We therefore propose that the districts identified in Chapter 4 be grouped into regions (see Map 5-1) and that in each region a regional office should be established; the regional office should be headed by an official whom we would call the Regional Director for Health Services, and it should include a full complement of resident support staff to assist the Regional Director in carrying out his/her responsibilities.

The Regional Director would provide complete liaison between the Ministry of Health and the District Health Councils, the institutions and the Area Health Services Management Boards in each district; that is, he/she would be the Ministry's sole representative in all matters pertaining to the health districts in the region. Because of the breadth of the Regional Director's responsibilities, this official must have sufficient authority delegated to him/her to carry out a wide range of functions. These would include

1. Informing District Health Councils and institutions of Ministry policies and changes in Ministry policies
2. Working with District Health Councils to implement policies in the light of local circumstances
3. Relaying to the Ministry the views of each district on proposed changes in policy

4 **Ibid.**, p.6.
5 **Ibid.**
6 **Ibid.**

4. Making decisions within provincial guidelines and standards; or, where policy does not exist, ensuring that decisions are made on the basis of information received from the appropriate level in the Ministry

The Regional Directors would be key figures in the development of the proposed health system. They must possess qualities of leadership and proven decision-making ability. As envisaged for the Area Planning Coordinators, their primary role would be to help districts to carry out their functions without imposing their personal views on the districts' decisions. In view of these requirements, the individuals who are appointed must be selected with particular care.

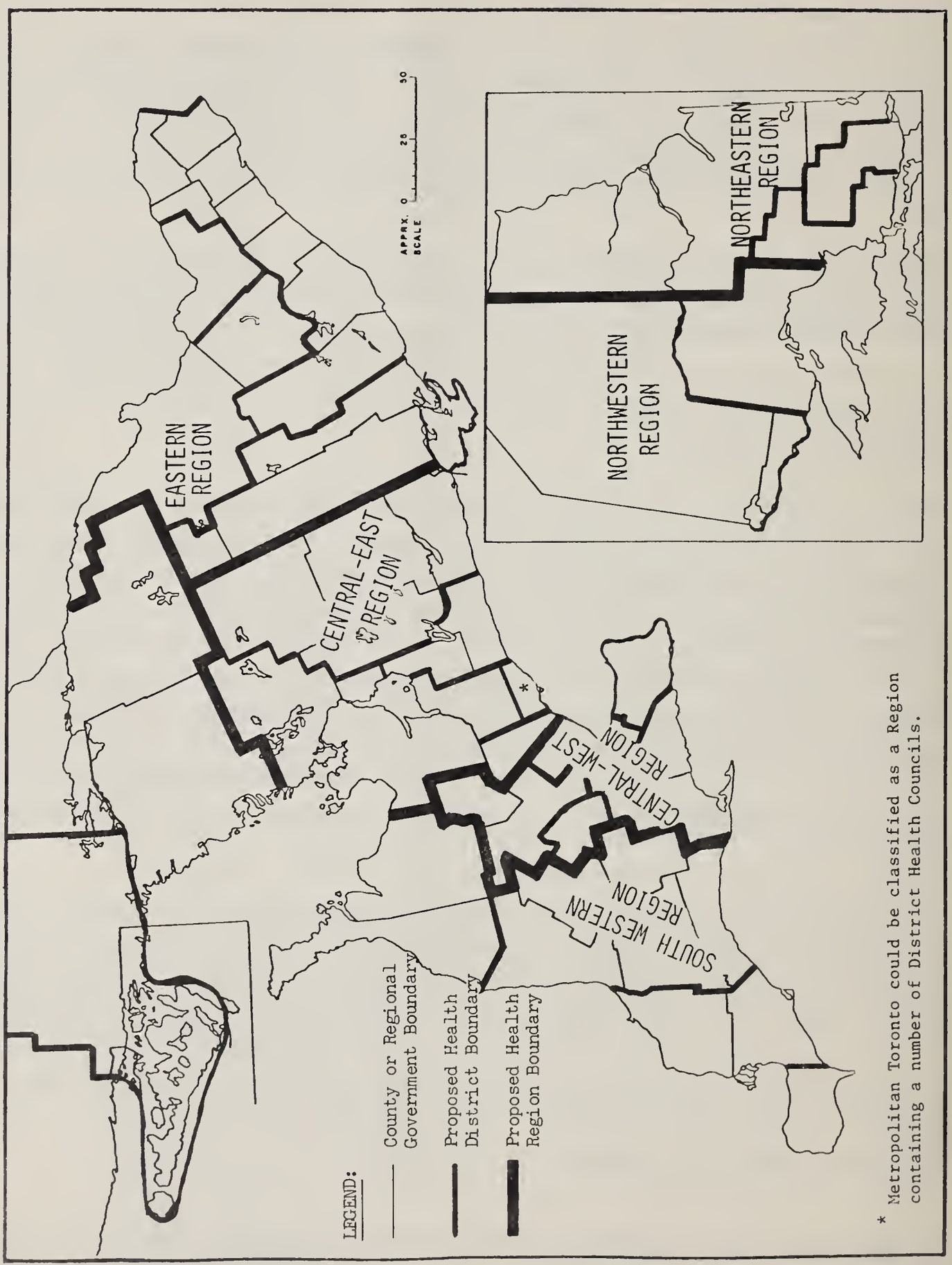
The Regional Director must have access to sufficient resources to equip the regional office with a full complement of qualified staff who are capable of dealing with the diverse matters that will come to the Director's attention. Among such staff must be persons skilled in finance, research planning, management planning and information systems. All supporting staff should be located in the region for which the Director is responsible.

It is essential that all material pertaining to district planning and area operations should pass through the office of the Regional Director, rather than being channelled into the Ministry's central office. Failure to abide by this requirement would defeat the attempt at decentralization which the regional office system represents. Matters that cannot be resolved at the regional level should be referred by the Regional Director to the Ministry, at the level of the Assistant Deputy Minister, Health Services. In addition, the Regional Directors throughout the province should meet frequently as a group with the Deputy Minister of Health and the Assistant Deputy Ministers, in order to keep themselves informed about policy and to advise the Ministry of developments and problems emerging at the district level.

It is intended that the Regional Director and the regional office staff should serve as a support to District Health Councils, institutions and Area Health Services Management Boards. At the same time, the officers and staff of the Ministry's central office must provide support to the regional offices. Specialists from the Ministry should be available to Regional Directors to participate in discussions of important issues with the Councils, their committees and particular delivery agencies. Ministry staff should be available also to contribute to studies of a particular problem within a district.

To facilitate the Regional Director's role in matters affecting more than one district in the region, he/she should have recourse to a committee composed of the Chairmen of all the District Health Councils in the region.

MAP 5-1
Proposed Health Regions and Districts



A frame of reference to guide the activities of the Regional Directors and their staffs will have to be developed, and the activities of the central office staff of the Ministry must be related to those of the Regional Directors. The central office staff should concentrate on overall objectives, policies, plans, priorities, guidelines and standards for the province as a whole, in order to provide the required support to the Regional Director, to District Health Councils, to Area Health Services Management Boards and to other institutions, groups and individuals.

A New Central Office Structure

In addition to the creation of a regional office system, full effectiveness in health care planning requires a restructuring of the Ministry's central office. Figure 5-2 illustrates the revised structure that we envisage.

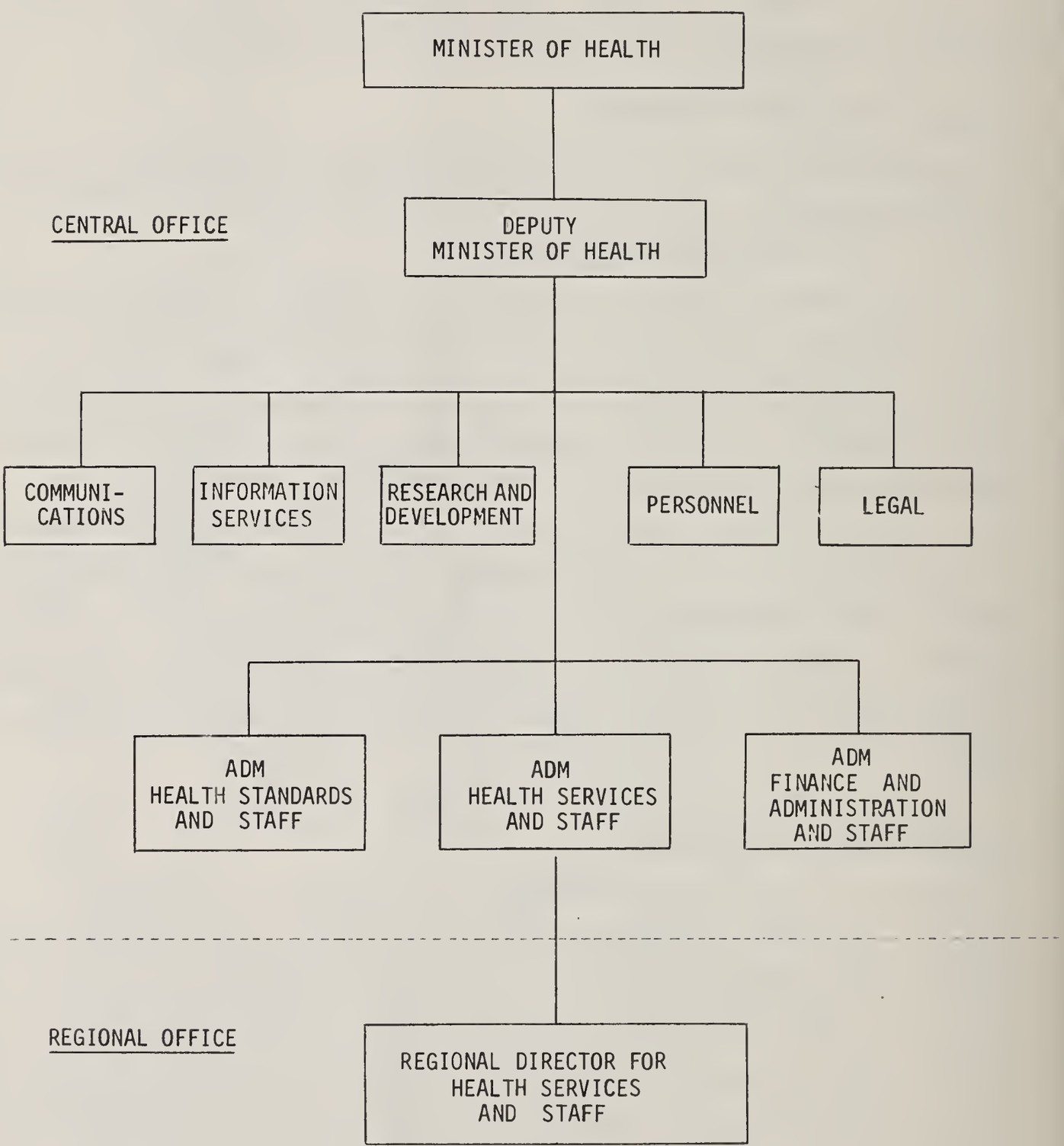
The role of a Regional Director is clearly vital to the operation of the health care system. The Health Services Group must be recognized as the operating arm of the Ministry, with direct line responsibility for operations. Within the context of operation, officials of the other two Groups would have an advisory relationship to the Health Services Group. The Regional Director must have access to support staff in all Groups in the Ministry in order to carry out his functions.

We would retain the Personnel, Legal and Communications Branches in direct line of responsibility with the Deputy Minister, and we would add to this level a Research and Development Division and an Information Services Division (presently in line relationship to the Assistant Deputy Minister, Finance and Information Services). The functions of these two divisions merit some discussion, since both have a major role to play in implementing the proposed health services system.

Research and Development

The Ministry's present research capability is very small. It is concentrated in the Research and Analysis Division, which is responsible to the Assistant Deputy Minister, Health Standards. There are three branches within the Divison: Research, Operations Analysis and Special Projects. Research and Operations Analysis are involved primarily in operations and financial research; Special Projects operates several grants programmes for the funding of extramural research. Included in the grants progammes are the financing of biomedical research (through Provincial Health Research Grants) and operations research related to the delivery of health services. Special Projects also funds departments of epidemiology and immunology in the province's various faculties and schools of medicine. Some provincially funded research is conducted by the several health foundations. Procedures have been established for coordinating the research activities of these groups, to avoid duplication and to ensure quality of research. At present, the Division undertakes no contract research, and there are no mechanisms for setting research priorities in the broad area of health care.

FIGURE 5-2
Ministry of Health Proposed Organizational Arrangements, Central and Regional Offices



LEGEND:

_____ line authority

_ _ _ _ _ advisory relationship

A D M Assistant Deputy Minister

Research and development is an essential component of the planning and decision-making processes in health care. We therefore recommend that this Division be given a separate function within the Ministry and that it be directly responsible to the Deputy Minister.

The Ministry's research and development capability must be sufficient to assess the current status of health knowledge with respect to the effectiveness, the availability and the efficiency of services and programmes. On the basis of this assessment, the Division should undertake or contract research into methods for improving the present system. The Division must be capable of evaluating proposals and preparing alternative plans and of evaluating the results of all research done in-house or on contract.

The Division also must have the capability to evaluate proposed new arrangements for health services and to devise alternatives, supported by cost estimates, for recommendation to the Health Program Committee of the Ministry of Health.

A most important role for the Research and Development Division will be the recommending of provincial priorities for health research. In this respect, it is essential that liaison be established with other government-funded and private research groups, so that the efforts of all who are involved in health research in Ontario may be coordinated towards some common objectives. The Division may undertake joint research with other groups where this seems appropriate. It must also develop a system for keeping Division staff fully informed and up to date on new developments in health research and health knowledge, both in Ontario and in other jurisdictions throughout the world.

We discuss the question of coordination and liaison between the Ministry and university and other research organizations in more detail later in this report.[7]

Information Services

Of equal importance to the development of a research capability is the need for a comprehensive data base to serve as a resource to the Ministry's many functions. The establishment and maintenance of such a base is the role of the Information Services Division.

The operation of the Division must be directed to avoid three potential hazards inherent in a data collection system:

1. That the data will be collected in a form suitable only for day-to-day administration
2. That the need for administrative information will pre-empt other requirements

7 See Chapter 7.

3. That decisions concerning the type of data that are collected, the way in which they are collected and the priorities for information gathering will be decided unilaterally by one operating area of the Ministry

At present, the Information Systems Division exists under the aegis of the Assistant Deputy Minister, Finance and Information Services. In view of the importance of this Division to all Ministry activities, we recommend that Information Services be relocated as a separate operation reporting directly to the Deputy Minister of Health. Decisions concerning priorities for information gathering must be determined, not by one division, branch or group in the Ministry, but by a senior committee composed of the users of the information. The Deputy Minister should be Chairman of the committee and should ensure that the Division carries out its functions within the established priorities.

Without in any way attempting to predetermine the decisions of the senior committee, we strongly urge that priority be given to collecting information required by the Research and Development Division, for this Division will rely heavily on Information Services in planning its research priorities. In addition, health services information should be made readily available in assimilable form to all levels of the health care sector that are engaged in the planning process.

The question of information gathering within the Ontario government as a whole is under study at present. We have no desire to make recommendations on a new or altered structure of information services that might confuse this already complex issue. We wish to state, however, that in our view the common information requirements of the entire social development policy field (including the Ministries of Health, Community and Social Services, Education and Colleges and Universities) should receive priority and that, because of their overlap in interest, their common needs should receive the highest priority.

Other Important Areas

There are two other areas on which we should offer some comments: the functions of the Communications Branch and the role of the Ontario Council of Health.

Communications

The Communications Branch serves the main purpose of transmitting facts about health and health services to the public. It has a commendable programme under way at present, providing information on such matters as family planning, venereal disease and vasectomies. It also performs a publications function for organizations linked to the Ministry, such as the Ontario Council of Health.

We urge that these activities be continued and that the Communications Branch devote a substantial part of its energies to the expansion of its information

programme. One of the guiding principles of the health care plan that we have devised is that health services be accessible to Ontario's residents, and an important component of accessibility is the cultivation of awareness among people that certain services exist. We see the continuation and expansion of the public information programme to be a major responsibility of the Branch in facilitating the full use of health care services in the province.

Another important role that should be undertaken by the Communications Branch is the development of a province-wide public education programme in the promotion and maintenance of health and in the prevention of accident and disease. An active and well-designed programme of this type would provide valuable support to the efforts of primary care groups in health education, and ultimately it could contribute significantly to the emergence of a more positive attitude towards health promotion and health maintenance than now exists in our society.

As a further support to the primary and secondary care sectors, the Communications Branch should work with various health foundations and the voluntary agencies in coordinating the dissemination of health care information throughout Ontario. It also should draw on publications initiated in other jurisdictions for information on health care.

As an immediate task, the Communications Branch should launch a public relations and information programme with respect to the proposals contained in this report, first, to ensure that they and their implications are fully understood by the public, by Ontario's health professionals and by Ministry personnel; and second, to keep all interested individuals informed about progress in implementing the proposals.

Role of the Ontario Council of Health

The Ontario Council of Health was established in June 1966 by Order -in-Council as the senior advisory body on health matters to the Minister of Health and, through the Minister, to the Government of Ontario.

Its terms of reference gave it a broad mandate to offer advice over the total field of health care in the province. Reports on its various activities have been issued on a wide range of subjects, including regional organization of health services, physical resources, health manpower, education of health personnel, library and information services, health research, health statistics, health care delivery systems, highly specialized services, laboratory systems, community health care, rehabilitation services, dental care services and the role of computers.

We see the Ontario Council of Health as performing a valuable role outside the administrative machinery of government. It has two main responsibilities: assisting in long-range planning, policy formulation and the development of guidelines and standards; and providing assistance in the resolution of specific and immediate problems in the sphere of health services referred to it by the Minister of Health.

The Council is important in another way as well. It is able to involve a variety of experts with diverse backgrounds from throughout the province on its committees, sub-committees and task forces, thereby benefiting from their combined expertise. In addition, this wide involvement provides a means of increasing understanding of new trends and ideas emerging in Ontario.

We believe that it is essential that the Ontario Council of Health continue to function in the two main areas of responsibility assigned to it.

6 Financing of Health Care

Health Care Costs in Canada and Ontario

Throughout our deliberations, we have been keenly aware of the fact that health care costs are rising rapidly both in Canada and abroad. In Canada, over the period from 1961 to 1969, the average annual rate of increase in health expenditures was 13.2 per cent (see Table 6-1). Although this rate of increase appears to be intermediate as compared with those of seven other Western countries, it was high enough to result in an increase in the relative size of the health care sector in relation to the overall Canadian economy from 6.0 per cent in 1961 to 7.3 per cent in 1969. Most noteworthy about these data, however, is the fact that of the seven countries considered, Canada allocated the largest proportion of its total resources to the health sector.

These increases in the expenditure on health care in Canada as a whole have been surpassed proportionately by increases in Ontario. As shown by the data in Table 6-2, between 1960 and 1971, expenditures on personal health care in Ontario increased by 263.0 per cent as compared to 254.4 per cent in Canada. In 1973, the cost of health care to the Province exceeded $2 billion.

These increases in Ontario's expenditures appear to result from the combined effect of five main factors. First, the Province introduced a hospital insurance plan several years before its present medical insurance scheme, and this gave the public and their physicians a clear incentive to use costly hospital care rather than ambulatory care. Second, the method by which hospitals are financed has sometimes encouraged hospital administrators and physicians to maximize the number of patient-days of care in their hospitals; at the same time, incentives to provide health services efficiently have been all but non-existent. Third, historically the hospital services sector was characterized by a sizable labour force that was satisfied to work for relatively low wages; during the past decade, however, there has been pressure for equalization of the wages of these personnel. Fourth, the relatively large amount of labour used in the health sector has meant that the overall increases in wage rates in the economy at large has had and presumably will continue to have a significant impact on health care expenditures. Fifth, and perhaps most significantly, despite its assumed role as the chief financier of health care, the provincial government has failed to develop a systematic, coordinated plan for the organization of the health sector.

TABLE 6-1

Total Expenditures for Health Services as a Percentage of the Gross National Product, Seven Countries, Selected Periods, 1961-1969

Country	WHO Estimates*		SSA Estimates**		Average Annual Rate of Increase in Health Expenditures***	
	Year	Percentage of GNP	Year	Percentage of GNP	Year	Rate of Change (per cent)
Canada	1961	6.0	1969	7.3	1961-69	13.2
United States	1961-62	5.8	1969	6.8	1962-69	10.1
Sweden	1962	5.4	1969	6.7	1962-69	14.0
Netherlands	1963	4.8	1969	5.9	1963-69	16.1
Federal Republic of Germany	1961	4.5	1969	5.7	1961-69	10.3
France	1963	4.4	1969	5.7	1963-69	14.9
United Kingdom	1961-62	4.2	1969	4.8	1962-69	9.5

* Brian Abel-Smith, **An International Study of Health Expenditure**, WHO Public Paper No. 32, (Geneva: 1967).

** Joseph G. Simanis, "Medical Care Expenditures in Seven Countries", **Social Security Bulletin** (March 1973), p. 39.

*** Office of Health Economics, London, "International Health Expenditure 11", Information Sheet No. 22 (May 1973), Table 2.

TABLE 6-2

Total Expenditures on Personal Health Care, Ontario and Canada, 1971

Expenditure Category	Ontario			Canada		
	Expenditure $000,000	Percentage of Total	Per Cent Increase 1960-71	Expenditure $000,000	Percentage of Total	Per Cent Increase 1960-71
All Hospitals	1,189	59.5	282.3	3,152	61.7	273.0
Physicians' Services	508	25.4	257.7	1,236	24.2	248.2
Dentists' Services	142	7.1	184.0	299	5.9	171.8
Prescribed Drugs	160	8.0	233.3	422	8.3	217.3
TOTAL	2,000	100.0	263.0	5,110	100.0	254.4

Source: **Ministry of National Health and Welfare, Expenditure on Personal Health Care in Canada 1960-1971,** selected data from Table 1 and Table 11.

Financing of Health Care Institutions

The biggest element of health care expenditures in Ontario is that used to finance hospitals. In 1971, hospital costs accounted for 59.5 per cent of the personal health care dollar in the province (see Table 6-2), while expenditures on physicians' services accounted for 25.4 per cent; those on dentists' services, 7.1 per cent; and those on prescribed drugs, 8.0 per cent.

Expenditures on hospital care have also been the most rapidly rising major component of the personal health care dollar. Between 1960 and 1971, they increased by 282.3 per cent in Ontario, while expenditures on physicians' services increased by 257.7 per cent (Table 6-2).

The overall significance of the hospital component of costs is substantially underestimated by the above figures., since they exclude payments made to the physicians who provide hospital services. If one includes the incomes of specialists who primarily use the hospital, more than 70 per cent of the Province's health expenditures is related to hospital care and less than 30 per cent is related to primary health care.

Clearly, if one is to establish some control on health costs, the area in which the greatest potential impact can be achieved is that of hospital care.

Our recommendations for the funding of hospitals and other health care institutions are based on the principle that any health care facility that receives any portion of its funds from the provincial government, for either operating or capital expenses, must be incorporated into the organization we are proposing for Ontario's health care services. Such integration is essential to the rationalization of resource use in the health care sector.

The Ministry of Health has recognized the need to restrict hospital expenditures and during the last few years has placed constraints on the overall increases permitted in the "global" budgets[1] of each hospital, on new capital expenditures and on the introduction of new programmes. The Ministry has also ordered certain institutions to close down certain beds where it appears they are underutilized or where alternative beds are available. This policy has reduced the trend of rising expenditures for the past two years. It is not known, however, whether these policies can be carried out for any long period of time without seriously damaging the delivery of health care. Furthermore, these restrictions are designed, not to produce a major realignment in the health care system, but rather to restrain cost increases.

1 A global budget refers to a fixed allocation of funds to an institution in a way that allows the institution to change its proposed programme of expenditures as long as it remains within the total approved amount.

As a guiding principle for the rationalization of institutional health facilities, the number of hospital beds available for various types of care should be brought into line with the number determined to be necessary by the District Health Councils within guidelines established by the Ministry. In some instances, the appropriate changes can be made by altering the existing functions of hospitals or of hospital wings. Where an excess in the number of beds persists, facilities should be consolidated by the closing of some units (hospitals or wings) in preference to making fragmentary cuts in all facilities.

In recent years, the Ministry has tended to restrict funds for institutional renovations; and in general it does not appear to have a clear policy in this area. The wise use of resources demands that appropriate arrangements be made to ensure the adequate maintenance and modernization of all hospitals and other health care facilities that are required for the health care system. In addition, there should be forward planning to ensure that the necessary arrangements are made for the future replacement of the capital plant.

Consistent with our underlying principle, all institutional facilities other than public hospitals, such as nursing homes, diagnostic facilities and privately constructed and operated hospitals, must be brought within the central planning control and organization of the District Health Councils whenever the construction and/or operation of these facilities involves use of government moneys. These facilities may ultimately come under the responsibility of the Area Health Services Management Board. Thus, proposals for the construction and operation of any government-funded facility must be approved by the District Health Council.

We would stress that these steps cannot be expected to produce immediate results. As an intermediary measure, however, the Ministry must recognize that in a period of inflation and at a time when hospital salaries and wages have not yet been equalized with those in other industries, the continued arbitrary restriction of funds to meet rising institutional costs may instigate major labour disputes and result in a lowering of health care standards.

We are aware that some of our recommendations will result in increased costs over the short term, but we urge that these be accepted in the interests of achieving long-term savings.

Remuneration of Health Professionals

We have considered a variety of methods that could be adopted to bring about a change in levels of remuneration for health professionals without incurring the difficulties that have been encountered in other jurisdictions.

This subject was considered at length by the Committee on the Healing Arts, which recommended a Fee Negotiations Advisory Committee, and more recently was re-examined in the Pickering Report. The Pickering recommendations seem to have

been largely adopted by the government, as indicated by the recent establishment of a Joint Committee on Physicians' Compensation for Professional Services. The following principles were incorporated into the plan for the Joint Committee:

1. The Committee is advisory, leaving the government with final responsibility for decisions on remuneration.
2. An opportunity is provided for the participation of both the Ontario Medical Association and the government through membership on the Committee.
3. An independent Chairman is appointed who has the responsibility of reconciling the various views put forward and has authority to make independent studies and to introduce his ideas to the other parties, either together or separately.

We support the establishment of the Joint Committee and recommend that its name be changed to **Remunerations Advisory Committee.**

The government has an important role to play in the Committee's undertakings. It must ensure that its membership on the Committee is as well informed and knowledgeable about the nature of health care and the abilities required to provide it as are the representatives of the profession. There should be a permanent staff in the Ministry of Health whose task is the assembling and continuing analysis of the information required for the Committee's deliberations.

Interested consumer groups should be able to make presentations to the Remunerations Advisory Committee. In addition, use should be made of the expertise of members of other committees and task forces who are concerned with the remuneration of health professionals. All the Committee's recommendations to the Minister should become public documents.

These proposals are broadly in line with the recommendation for a Fee Negotiations Advisory Committee made by the Committee on the Healing Arts. They are also an extension of the basic philosophy of the Pickering Report.

Nevertheless, we recognize that the establishment of the Remunerations Advisory Committee for physicians is only the first step in building a system for determining the details of funding arrangements for all health professionals (nurses and other health professionals, as well as physicians).

The establishment of such a system is essential to facilitate the functional groupings of health professionals proposed in this report. If this is not done, there is a danger that the development of interprofessional relationships will be hampered. One alternative would be to establish a Remunerations Advisory Committee which would include representatives of the health care professionals other than physicians. A second alternative would be the establishment of a number of Remunerations Advisory Committees for the various professional groups. If this second alternative were followed, it would be necessary to establish a mechanism for coordinating the work of the several committees.

It should be emphasized that the Remunerations Advisory Committee will have to relate to those provincial bodies, both government (the Health Disciplines Advisory Committee) and professional, whose functions are job classification and discipline. We recognize that the relationship is extremely complex, and that its successful evolution will require time and experience. Since the problems of remuneration and those of role definition or job description for the various categories of health care personnel are highly interdependent, the Remunerations Advisory Committee must necessarily consider issues in both areas. Its principal role, however, will continue to be to advise government on issues of remuneration.

With regard to the regulatory bodies of the professions, whose present concern is with matters of job classification and discipline, we support the establishment of an overall coordinating mechanism (the Health Disciplines Advisory Committee) to which the Ministry of Health could turn for advice; for the Ministry, on behalf of the public, has an important role to play in settling matters of job classification. In particular, if the concept of the primary care group is to develop to its full potential, it will be necessary that the present system of rigid role definition be broken down and that a new, more flexible procedure be developed.

Remuneration of Physicians

Broadly speaking, there seem to be two major alternative methods of government financing of physicians' services: **direct payments to providers,** sometimes referred to as **tiers payant**; and **reimbursement of patients,** sometimes referred to as **tiers garant.**

We have rejected the reimbursement-of-patients method as the primary method of financing in Ontario since its major expected advantage–namely, the possibility of introducing a part of the forces of the marketplace into decisions on the purchase and provision of health care–seems to be outweighed by the disadvantages. Among these are the following:

1. Almost all variants of the **tiers garant** method seem likely to deter low-income patients from using services. Variants that are based on payments geared to income raise the further problem of defining the individual's income and the need to adjust payments as income levels change.
2. The administrative costs are prohibitive when reimbursement must be made on individual patient claims.
3. Most importantly, there is evidence that market forces do not in fact operate freely when health care is based on reimbursement to patient. In the absence of a universal provincial insurance scheme, about 75 to 85 per cent of the population will obtain insurance either through their employer or through private plans; another 5 to 15 per cent will be low-income institutionalized persons whose health care is fully supported by the government; and only the remaining 5 to 10 per cent would actually pay

the physician out of their own pockets. Thus, the intended checks on the use of services would be negated.

Although we have rejected for the present the reimbursement-of-patient as the primary method of financing health care, we recognize that further studies should be made of alternatives that will deter the unnecessary use of services by patients and the provision of unnecessary services by physicians, both of which are a risk of the tiers payant system.

For the present, we recommend the use of some variant of the remuneration-of-provider system of health care financing.

We have considered the salary, capitation, case payments and fee-for-service systems of remuneration, and we find that the principle of the fee-for-service system has at least as much to offer as the other systems. The present operation of the fee-for-service system in Ontario, however, is thought to be in need of modification.[2] It is subject to abuse by some physicians; it can militate against the development of a coordinated health care delivery system that includes the efficient use of allied health care personnel; it may overemphasize the provision of curative rather than preventive services; and it can involve the inequitable remuneration of certain categories of physicians, which in turn contributes to a maldistribution and improper mix of medical manpower.

These problems cannot be laid entirely at the door of the medical profession, notwithstanding considerable public criticism to this effect. It should be understood by the public that the introduction of medicare by the government automatically increased physicians' incomes.[3] The higher incomes resulted primarily from three factors:

1. Physicians have traditionally given part of their time in free service to indigent patients; under the new system, they were paid for these services.
2. Physicians have traditionally forgiven many of the debts owing by patients if they felt that payment would cause financial hardships; under medicare, they were guaranteed 90 per cent of the fee scale for services rendered to all patients, regardless of whether they were hardship cases.
3. The removal of the financial barrier to the patient has presumably led to increases in the volume of the services provided.

These problems inherent in the existing method of operating the fee-for-service scheme will require action on two fronts. First, certain changes must be made in the

2 The present operation of the fee-for-service system in Ontario should not be construed as being the only way in which a fee-for-service system can be set up.

3 Indeed, many in the medical profession warned that the introduction of medicare would increase costs.

present operation of the system. Second, greater experimentation should be undertaken with such alternative methods as salary, salary plus expenses, global budgeting for ambulatory care, global budgeting for ambulatory and hospital care, and combination schemes such as capitation plus fee-for-service, to facilitate the development of new arrangements. Of the available alternatives, the arrangement that we endorse is a system of unit billing for primary care groups. This system is described below in the section dealing with the remuneration of allied health professionals.

The first and most important of the changes that should now be made is that the relative and absolute level of benefits payable to physicians under the government plan for services rendered should be resolved through discussions of a special unit of the government and representatives of the health profession to thereby establish an approved benefit-for-service schedule. This schedule would be established with the goal of attempting to ensure a reasonable payment for the service rendered, taking into account the quality of the service as well as the benefits derived from it.

These discussions seem particularly important in order to bring about a realignment of levels of remuneration from the public purse of the various categories of health care personnel in order to provide equity and, equally importantly, to encourage people to enter those areas of practice where the public need is greatest. We fully support the attempts of the professional bodies to achieve this realignment.

The special unit of government and the medical profession could give highest priority to the consideration of the methodology being developed by the Medical Review Committee of the Ontario College of Physicians and Surgeons. This Committee has set forth the number of units of service in terms of the maximum amount of time that can be provided by the various broad categories of physicians consistent with maintaining quality of care. A schedule for prorating the benefits payable to individual physicians for services as their workload increases might then be established, with the proration of fees starting before the established maximum income levels are reached.

If the government cannot develop suitable units of service and regulation of manpower, it might be forced to limit the total expenditures on physicians' services. An annual "global budget" could be set for all services provided by physicians. Benefits payable by government could be prorated on an across-the-board basis to just exhaust the budget in any given year.

Remuneration for Educational Services

Wherever possible, the work of physicians in education should be paid for out of the educational budget. At this time, however, the techniques for determining the source of costs for education or for service are not well developed. Further study of this area is required. In the meantime, the Province's funding arrangements should ensure that the dual roles of individuals in education and service are not distorted.

We also urge the use of a coordinating mechanism between the Ministry of Colleges and Universities and the Ministry of Health for the funding of health education.

With the emergence of primary care groups, it will be essential to make special remunerative arrangements for primary care physicians who undertake clinical teaching in the group setting, to ensure that their assumption of such responsibilities does not result in an unreasonable loss of income.

Remuneration of Specialists

The following principles should be followed in reimbursing specialists for professional services. First, techniques or procedural differentials – that is, those differentials in payment that are based solely on differences in educational qualifications for given techniques or procedures – should be eliminated. Second, primary care provided by specialists should be reimbursed at primary care rates. Third, specialists should not normally be reimbursed at specialists' rates for services rendered to patients who have not been referred from the primary care sector. The details for carrying out these principles, some of which have been worked out by the government and the medical profession, should be a continuing responsibility of the Remunerations Advisory Committee.

We have been concerned with the use of hospital facilities by some hospital-based physicians which leads to the generation of incomes that seem to be excessively high. This problem should be the subject of early study by the Remunerations Advisory Committee, and appropriate sections of the schedule of benefits payable to physicians should be revised as the Committee deems desirable.

We have noted the development of a statement on ethical billing[4] by the Ontario Medical Association and the College of Physicians and Surgeons dealing with the practices of full-time specialists and specifically with their billing for services rendered in whole or in the large part by residents and interns. We support this development and urge the establishment of suitable mechanisms for monitoring these practices.

We have also considered the possibility of placing all hospital-based physicians on salary. While we are not endorsing this alternative at the present time, we note that this method of remuneration is clearly acceptable to many hospital-based specialists and to the hospitals in which they work and that the adoption of such a system may well be feasible at some future date.

Financing of Laboratory and Radiology Services

At present, individuals providing radiology and laboratory services are remunerated on a fee-for-service basis. A very high volume of services is performed, often by a staff of technicians under the supervision of a qualified pathologist or physician.

4 The College of Physicians and Surgeons of Ontario, **Annual Report,** June 1972, pp. 4-5.

Under the OHIP system, fees for service are charged at professional rates, even though the services are support services, provided mainly by support personnel. Consequently, laboratories – particularly those outside health care institutions – generate very high incomes.

To resolve this problem, we accept the proposal set forth in the report of the Primary Advisory Group on Medical Care Insurance Review[5] that the benefits payable to all pathologists and radiologists should be revised so that payments reflect only the professional component of the service provided. The cost of the capital equipment and the operating cost of the laboratories currently obtained through the revenue generated by the fee-for-service schedule should be covered by an alternative method which is based on the actual cost of providing the service. The Report on Laboratory Systems emphasized the need for district systems in laboratory medicine and appropriate financial arrangements.[6]

Remuneration of Allied Health Care Personnel and Unit Billing

One of our prime concerns has been to develop a method for promoting the effective use of allied health care personnel in the primary care setting. We have concluded that a system of unit billing should be developed for services delivered by the group. Under this system, primary care groups would be permitted to bill for each unit of service included in an approved benefit-for-service schedule, regardless of which health professional or combination of professionals actually performed the service.

A single, consolidated submission to the government would be made on a regular basis by each primary care group for reimbursement for all the services rendered by all the health care personnel during a specified period. Reimbursement for these services would be directed in a single payment to the primary care group. Each group would, in turn, be expected to determine for itself the method by which each health care professional would be remunerated.

In order to enhance the provision by primary groups of an increased emphasis on preventive care, a type of capitation scheme of funding could be developed in conjunction with unit billing for other health services. This incentive programme would be restricted to physicians who were part of an accepted primary care group. Adjustments in the benefit-for-service schedule also could accomplish the same end.

The development of a system of peer review and audit of health services in primary care should help to restrict any tendency towards overservicing.

5 The Report of the Primary Advisory Group on Medical Care Insurance Review to the Ontario Council of Health, March 1973 (awaiting publication – January 1974).

6 **The Report of the Ontario Council of Health on Health Care Delivery Systems**, Supplement No. 7, Laboratory Systems (Toronto, 1970), p.p. 23, 26.

To encourage the early use of nurses and allied health care personnel in primary care groups while the unit billing system is being developed, a direct incentive programme could be introduced whereby a portion of the salary of each of the nurses and allied health care personnel to join the primary care group was paid by the government directly to the group. The latter could then itself determine the method for reimbursing each of the members.

In order to promote the efficient use of personnel under this interim incentive scheme and to prevent the generation of increased incomes for the physicians in the group, it is essential that standard procedures of accountability be established.[7] Should this incentive programme nevertheless generate unjustifiable increased incomes for physicians, the Remunerations Advisory Committee should advise the Ministry on revisions to the approved benefit-for-service schedule in order to counteract such increases.

In the first stages of its use in Ontario, this programme should be considered as a fairly large-scale pilot project which should be subjected to detailed evaluation on an annual basis.

With the evolution of the unit billing system, the need for the incentive programme should decrease to the point where it can be discontinued.

Where such personnel as social workers provide part of the total package of health care to individuals, their services should be included as insured benefits and these personnel should be included as an integral part of the primary care group and remunerated on the same basis as other allied health personnel. Thus, they would become part of the unit billing system or would be remunerated through other methods, such as global budgeting, that may be developed for reimbursing primary care groups.

The Premium System

We feel that the present premium system for financing the Ontario Health Insurance Plan may well have outlived its original purpose of ensuring that members of the public are kept aware of health care costs, since the majority of premiums are now collected as part of the overall wage or salary package of employees. But in view of the fact that the system currently generates $520 million annually for the Province, it is unlikely that it will be discontinued.

7 In particular, in order to prevent the use of such personnel for providing billable services only, to the exclusion of non-billable services, the subsidy should probably be paid ex post and be based on a log kept of the time devoted by the health professional to the provision of non-billable services, where billable services are defined as those that appear on the approved benefit-for-service schedule.

Without the compilation of such a log, there would be an incentive for physicians to use allied health personnel in their provision of billable services only. Thus, services that are not now part of the fee-for-service schedule but are nevertheless thought to be valuable services rendered by allied health personnel would likely be provided less frequently than desirable. The keeping of such logs would, of course, also be an essential ingredient in planning for the effective use of all health care personnel in the primary care group.

7 Health Manpower, Education and Research

The quality and effectiveness of the health care system that develops in Ontario will be determined in part by the number of personnel available to provide services and by the attitudes and expertise of health professionals. In this chapter, we will examine the problem of meeting manpower requirements and briefly review programmes for educating health personnel. We will also describe the present and future health research needs of the Province.

Health Manpower

The number and types of health personnel that are available to provide services directly affect the quality, the quantity and the cost of health services. It is therefore important to be able to predict accurately the precise numbers and the mix of personnel required to meet all the needs of Ontario's residents. At this stage, however, it is very difficult to do this. The problem has been described in a recent study for the Science Council of Canada:

> Few tasks could be more frustrating than that of calculating the manpower needs in a system as amorphous and changeable as health care....We have noted some 35 studies (of which at least 6 can be classed as major) currently in progress, in various parts of the country, that touch upon the issue of manpower. Besides these there are undoubtedly many more being carried out by Federal, Provincial and other bodies. This represents a very substantial effort in a good cause: to find out how many people there should be at any given time to do the job. In the process of searching for answers, much has been learned and the exercise is well worthwhile from many points of view; but the chances, at the present time at least, in making anything like a confident projection in any aspect are remote because there are many unknowns.[1]

Some conditions that influence the supply of health professionals are

1. The Province's education programmes for all health personnel
2. The level of remuneration of health personnel
3. Living and working conditions in particular geographic areas
4. Immigration policies
5. Licensing policies
6. The perceived status of various professional groups

1 H. Rocke Robertson, **Health Care in Canada: A Commentary**, Background Study for the Science Council of Canada, March 1973, p. 86.

Modification of any of these factors can have a significant impact on the available manpower.

Despite the difficulties involved in making manpower projections for health care, we recognize the necessity to determine the demand for services and to adjust the number of personnel accordingly. Our concern is not merely to adjust upwards – that is, to increase the number and skill mix of the personnel available. In some instances, it may be necessary to impose limits on the maximum number of practitioners in certain professions that can operate in the province or in particular districts of Ontario. This applies most significantly to the supply and distribution of physicians, for they generate more and heavier service costs than any other group of health professionals in Ontario. Thus, an oversupply or maldistribution of practitioners can have a very strong impact on the quality of health care as well as the overall cost of health services in the Province.

At present, Ontario has a very favourable ratio of physicians to population (1:586); indeed, this is one of the most favourable ratios in the Western World. Some observers[2] have commented that, in terms of numbers alone, there appear to be enough physicians practising and enough training physicians in Ontario to meet the foreseeable needs for services. There is, however, a maldistribution and a shortage of certain skills in many areas of the province; and at the same time, the danger exists that an oversupply may develop in other skill areas.

An important factor affecting the present supply and skill mix of physicians is the substantial influx of qualified practitioners from other parts of Canada and from other countries. Table 7-1 indicates the training background of physicians licensed in Ontario between 1968 and 1972.

The table shows that almost two-thirds of the physicians licensed in Ontario in 1972 took their training outside the province. Large numbers of these physicians are specialists.

If control over the number of physicians practising in Ontario is considered to be necessary, there are several alternative methods for achieving this end. One method might be to limit the number of licences issued to physicians from other jurisdictions. The major advantage of this method is that it could be implemented promptly, if the government felt that it had to impose controls quickly. Priorities for licensing would be established to give graduates of Ontario medical schools preference over graduates of other Canadian schools and over those who are foreign trained. This system, however, has some serious disadvantages. Primarily, it would discriminate against qualified practitioners from outside Ontario and thereby contravene one of the provisions of the Ontario Human Rights Code. The Code reads that "no self-governing profession shall exclude from membership or expel or

2 W.B. Spaulding and W.C. Spitzer, "Implications of Medical Manpower Trends in Ontario, 1961-1971", **Ontario Medical Review**, September 1972.

TABLE 7-1

Ontario Physician Manpower Sources, 1968-1972

(By year of initial registration)

Year	Ontario Medical Schools		Other Canadian		Foreign		Regular Register Total	
	No.	%	No.	%	No.	%	No.	%
1968	278	45.4	116	19.0	218	35.6	612	100
1969	284	38.8	128	17.5	320	43.7	732	100
1970	340	36.9	200	21.7	382	41.4	922	100
1971	342	35.9	158	16.6	452	47.5	952	100
1972	359	35.1	164	16.0	501	48.9	1,024	100

Source: College of Physicians and Surgeons of Ontario, Registration Statistics, December 31, 1972.

suspend any person or member or discriminate against any person or member because of race, creed, colour, age, sex, marital status, ancestry or place of origin."[3] The government could legislate to permit such discrimination in this case, but we would not advise this, since each exception made tends to erode the general principle of the Code. Furthermore, we feel that restrictions of this nature would in the long run lead to a decline in the quality of health care in the province. Ontario has benefited enormously in the past from the influx of qualified professionals from other jurisdictions, and it should continue to do so.

Another possible means of controlling the supply of physicians in the health system is the global budgeting form of remuneration proposed by the Ontario Council of Health's Medical Care Insurance Review.[4] Obviously, a restriction on the funds available for payment for physicians' services would act as constraint on the number of physicians practising in the province. This type of budgeting would not, however, affect the distribution or the mix of practitioners throughout Ontario. Moreover, we believe that global budgeting for physicians' services might hamper

3 Ontario Human Rights Code, Section 4a (2).

4 The Report of the Primary Advisory Group on Medical Care Insurance Review to the Ontario Council of Health, March 1973 (awaiting publication January 1974).

the development of the personnel groupings we have proposed for the delivery of health services. We therefore reject this alternative as being unacceptable to our overall objectives.

A third alternative, and the one that we endorse, is the establishment of guidelines for determining physician requirements for each district in the province. As we have suggested in Chapter 4, District Health Councils should decide on the number of positions and the various types of general/specialty positions required, in accordance with broad guidelines set by the Ministry of Health. The Council's recommendations would be subject to the Ministry's approval. Such approval would provide that OHIP registrations would automatically be granted for the positions in the establishment. There would have to be frequent reviews of the establishment, and appropriate adjustments would be made as changes occurred in the delivery of health care.

All health professionals presently in practice in the district would become part of the district establishment. This would include physicians who are at present registered through OHIP but do not participate in the Plan.

A physician wishing to practise in the district would ascertain whether there was a vacancy in the district for his service. If there were and he were appointed to fill it, he would be registered with OHIP. If there were no vacancy, he would not be registered. Physicians who wished to practise in a district that had no opening might do so; but because they would be excluded from OHIP, they would have to make their own arrangements for payment with their patients. Thus, a private health care system could develop alongside the provincially funded health system.

We believe that the system we propose can influence the supply and distribution of physicians throughout the province in relation to local needs. It can also provide a means of estimating and projecting the health care requirements of Ontario's residents, thereby enabling the rationalization of resource use that is essential to an efficient and effective health care system. This mechanism should be applied to all health professionals in the system.

Education of Health Personnel

Clinical Education

During this century, the clinical education of most health personnel has become concentrated in teaching hospitals. The majority of these institutions have become referral centres for patients with complex or unusual illnesses, and many serve as centres for clinical research.

Until recently, the health sciences centres have focused on clinical programmes in specialized medicine, and little effort has been directed to clinical training in primary care settings. This has contributed to a loss of status for health personnel providing primary care services and consequently has had a harmful effect on the

attitudes of students and health professionals about this sector.[5] There is evidence now, however, of new trends for broadening the educational experience of students. Attempts have been made to replace the traditional, relatively fixed and formal regimen with a more flexible system that gives the student opportunities to explore various areas of interest. In many schools of medicine, new departments have been established centring on family medicine or general practice. In some instances, these programmes are linked to education for nurses in primary care.

Concern has been expressed that these changes may lead to a downgrading of specialized medicine and diminish the role of the teaching hospital. The development of programmes with a broader base does not, however, mean the downgrading of existing clinical programmes; rather, it requires their integration into more comprehensive programmes. The goal, as we see it, is to provide clinical education programmes that are based on health services in a district rather than solely on the special services within hospitals as at present. Such programmes should be organized in the primary and secondary care sectors on a district basis.

In describing the kinds of arrangements that will have to be made for these programmes, we will use as an example the clinical education of physicians; our comments and suggestions can, however, be applied to the education of other health personnel as well.

An essential component of clinical education is the supervision of a student's instruction. In the secondary care sector, the conventional teaching hospital has played a major role in developing the clinical skills of nurses and physicians. High standards have been established in this setting in terms of the experience and self-discipline acquired by students.

Supervised clinical instruction must be maintained and developed in the secondary care sector. The physicians primarily responsible for closely supervised instruction in teaching hospitals should normally be given appointments as full-time members of the teaching staff. The clinical faculty also should include practising specialists who are willing to undertake less intense supervision, accepting more experienced students into their office or hospital-based practice. These physicians should normally be appointed as part-time members of the teaching staff.

Supervised clinical instruction also must be extended to the primary care sector. Full-time clinical teaching appointments must be arranged similar to those developed for hospital-based specialists. A move in this direction has already been made with the establishment of Departments of Family Medicine or Community Medicine in the Faculties of Medicine of Ontario universities. In the case of less

5 The Committee on the Healing Arts recognized the role of the educational institutions in promoting attitudes of inferiority among general practitioners, and it made a specific recommendation for improving the situation. See **Report of the Committee on the Healing Arts** (Toronto: Queen's Printer, 1970), Vol. 3, pp. 192-93, 200-3.

closely supervised instruction, a problem exists in that the supervising physician provides proportionately less service to patients as the teaching commitment increases. Any arrangements that are made for clinical instruction in primary care must provide for adequate supervision without detracting from the quantity and quality of services available in a given group. Care also must be taken to ensure that the assumption of teaching duties by the primary care practitioner does not result in an unreasonable loss of income for that practitioner.

Under the arrangements that we are proposing, clinical education would take place throughout the health service programmes in each district. Thus, no one health care institution would have a special categorization or preferred status, such as a teaching hospital enjoys in the conduct of clinical education. Special teaching units could, however, be provided within service programmes, and some institutions or primary care groups could contain a greater number of these than others. The system we propose has the advantage of avoiding the conflict that has arisen in the past, with respect to the simultaneous provision of educational programmes and of health care services; regrettably, some health professionals have tended to exploit their educational role to gain special privileges for their service function.[6] Such exploitation should not be permitted, and the arrangement we suggest should prevent it.

In advocating the extension of clinical education to the primary care sector, we are not suggesting that the existing centres for clinical work and clinical research be weakened or replaced. We are in full support of the worthwhile programmes in teaching and research that have been established in clinical settings.

Training in the Team Approach

It is essential to the development of an effective, integrated, coordinated health system that students be equipped with the skills and attitudes that will allow them to coordinate their activities with those of other health personnel. The most appropriate setting for the education of students in the use of the team approach is the clinical facility in which the team actually operates. Arrangements therefore must be made for the clinical education of health personnel in a primary care group or a secondary care programme, depending upon the individual's chosen area of interest. To encompass all categories of health personnel working in the group or programme, clinical training must include, when appropriate, students from community college programmes, as well as those from university programmes. The cooperation that is developing between the universities and colleges of applied arts and technology should make these developments possible. The Health Sciences Coordinating Committees that have been established in a number of centres can serve as a focus for the coordinated use of both preclinical and clinical resources for the education of health personnel, the development of appropriate clinical settings

6 This problem also was recognized by the Committee on the Healing Arts. **Ibid.**, p. 127.

to bring together members of these health teams at appropriate times during their education, and the coordination of educational programmes to facilitate the streaming and transfer of some students. Other committees and Ontario government officials have recently recommended developments along these lines.[7]

We note that although nurses have traditionally been educated in a clinically focused programme, there is concern that the modification of diploma programmes for nurses has moved in the opposite direction. Consistent with the development of a team approach to health care delivery, nursing education must be restructured to include clinical training in both primary and secondary care.

Continuing Education

A major problem for health professionals is maintaining a satisfactory level of competence in a field where knowledge and technology are constantly changing. We feel that the professional schools have an obligation to instill in their students the attitudes and habits of work essential to the pursuit of continuing education.

Continuing education may take a variety of forms. It is generally conceded, however, that the standard two or three-day refresher course is of limited value and affects only a small number of practising professionals.

Several steps may be taken to promote an interest in continuing education and thereby to maintain professional competence:

1. Involvement of practising personnel in the clinical education of undergraduate and postgraduate students
2. Evaluation, as recommended elsewhere in this report, based on a health audit and peer review of performance
3. Provision of appropriate refresher courses (that is, of two to three months' duration) by educational institutions
4. Regular visits of teams from health sciences complexes to district groups and programmes to give courses and conduct discussions on subjects of interest to local professionals
5. Development of self-assessment programmes

7 See **Report of the Committee on the Healing Arts** (Toronto: Queen's Printer, 1970), Vol.3, pp. 100-10; the Ontario Council of Health, **Future Arrangements for Health Education,** 1971, pp.28-29; and the Ontario Ministry of Health, **Guiding Principles for the Regulation and the Education of the Health Disciplines,** January 1971, pp. 7-9.

New Education Programmes

The development of an integrated, coordinated health care system for Ontario requires the parallel development of new or restructured educational programmes. The most immediate need exists in three main areas: administration programmes, programmes for health research personnel and diploma programmes for allied health professionals.

Administration

The development of an integrated and coordinated health care system will require skilled administrators that can create the arrangements needed by health professionals in providing their services. Experienced administrators in the health field are rare enough, but individuals with the knowledge and skills to promote the type of system we are proposing are even scarcer. We recommend that programmes for administrators in health services be developed within the universities of Ontario.

Health Research Personnel

To maintain its efficiency and to accommodate changes in the health care field, the health services system must have an effective research and development capability. An important aspect of this is the training of research personnel.

The universities of Ontario should be encouraged to develop programmes for the training of health researchers, particularly in the area of applied, developmental and health services research, which at present are underdeveloped in Ontario. There is currently a serious shortage of health research personnel, partly because the existing constraints on health and university expenditures make it difficult to attract individuals into these areas. To offset this trend, career positions for health services research staff should be established within universities and throughout the health system. In addition, university programmes in health research should be developed in coordination with the personnel and research needs identified by the Ministry of Health through its Research and Development Division. We shall discuss the Province's needs in the broad area of health research in the next section of this chapter.

Advanced Programmes for Diploma and Other Graduates

In recent years, there has been a trend towards the extension of educational programmes for allied health personnel such as physiotherapists, occupational therapists and nurses. In order to provide some individuals in these professions with opportunities to develop their skills and assume more responsibility than is normally associated with the provision of such services, the educational requirements for the entire profession have been raised. We feel that this is not necessary for all professions, and it may indeed be undesirable. If trainees are required to undergo a long period of formal training before they qualify, a

substantial number of individuals may be deterred from entering the profession who would otherwise have served very well; and those who do complete the programme may find that when they seek employment the jobs that are available do not require all the skills and the knowledge that they have acquired. In order to avoid the frustrations and diseconomies inherent in overtraining personnel, we recommend that diploma programmes be retained, providing trainees with the essential qualifications required in their profession; and that more advanced programmes be made available as well, so that those who have the motivation and the ability to obtain additional skills and knowledge may do so, regardless of their formal qualifications.

Health Research

As we have emphasized in Chapter 5, it is essential that Ontario direct a significant effort towards the expansion of its research and development capabilities in the area of health care. A recent report to the Ontario Council of Health has formed the basis for a number of important proposals for the direction of the Province's future research effort.[8] We shall describe briefly the recommendations for research planning contained in this report.

Research can be classified into two broad categories:

1. Research whose primary goal is the provision of new knowledge. This category includes basic, applied and developmental research.
2. Research concerned with the implementation and distribution of new knowledge that has proven useful and which will yield demonstrable benefits in excess of costs; and research directed at methods of improving the efficiency with which all health services are provided.

The report included a table showing a breakdown of current and proposed expenditures on each category in Ontario (see Table 7-2).

It was proposed that, to obtain the appropriate level of expenditure in health research and an appropriate distribution in a comprehensive research programme, support of basic research should continue at the present level, while more support should be directed towards applied and developmental studies. Also, the report proposed that support of research concerned with the implementation and distribution of new knowledge and the efficiency of health services should be increased.

In a subsequent report,[9] the Committee on Health Research of the Ontario Council of Health has outlined a health services research programme for Ontario. This is based on four main components:

8 R.D. Fraser, **The Economics of Health Research,** A report to the Ontario Council of Health (awaiting publication – January 1974).

9 Ontario Council of Health Committee on Health Research, **Health Services Research,** August 1973.

TABLE 7-2

Expenditures on Health Research in Ontario as a Percentage of Health Care Expenditures

Type of Research	Percentage of Expenditures	
	Present (1971)	Proposed
Industrial	0.46	0.5
Non-industrial		
1. Research into the provision of new knowledge		
Basic	0.82	0.75
Applied and Developmental	0.82	2.25
2. Research into implementation and distribution of new knowledge and efficiency of the health services delivery system	0.10	1.0
TOTAL	2.20	4.5

1. The Ministry of Health should develop the capability to conduct research relating to its management activities, to carry out short-term and long-term research in the second research category, and to develop a programme in contract research with suitable mechanisms to control quality.
2. The university health sciences centres should have an expanded role in respect to the education of research personnel and the scope of their research activities. They would have to be capable of carrying out both mission-oriented and contract research, and they would be required to work in collaboration with the District Health Councils and be responsive to their needs.
3. The District Health Councils should develop a research capability related to their planning functions and linked to the university health sciences centres.
4. A health services research centre should be established to conduct short-term, intermediate and long-term research of the second category.

Mechanisms would have to be established for coordinating the research activities of the Ministry, the universities' health sciences centres and the District Health Councils, and for linking the health services research centre with various Ministries in the government, with universities and with the community.

We strongly endorse the health services research programme recommended by the Committee. The development of an effective, coordinated research capability at the Ministry, university and community levels will go far towards improving and rationalizing the provision of health services in Ontario.

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